Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JANUARY 31, ZOOB **Physician** 12:15FM Earl Α. Ray /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. MM 2□ F 10-24-1930 Maryland 77 215-28-7857 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State or items 23a or 28a-f show aminer must be notified at 1 ☐ Yes 2√No Lutherville Director Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2 should be filed within 72 hours after death with 1 and Mental Hygiene.
is marked other than "natural", or items 23a or 2 USA 21093 1446 Burton Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? ★XXYes 2☐No If Yes, Give Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes → No Specify: Specify: white þ 3XXVidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Catalyst Research Tool & Dye Maker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gaffeliah M. Troyer William Thomas Ray 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sl
Department of Health an
Important: If item 27 is r
any injury or other traur Lutherville, MD 1446 Burton Avenue Daughter Winifred Williams 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veteran Cemetery 2/7/08
at Garrison Forest 20c. Location - City or Town, State 20a. Method of Disposition ₩XBurial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signarire of Funeral Service Licensee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland Baltimore, Maryland 21211 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONIA **Physician** /Medical Due to (or as a consequence of): CHRONIC OBSTRUCTIVE PULMONARY DISEASE Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and the burial-trag Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown CONGESTIVE HEART FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 🗌 Yes Medical Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Ledical Examiner: On the basis of examination and/or investigation in success 29a. Certifier edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2008 DØØ17695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

ABDALLAH

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OSLER DRIVE, TOWSON,

MARYLAND 21204

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pester mile ~ 130/08			in 24 h	edic	(Check only 2 Medical Exam	iner: On the b	asis of examina	ition and/or inv	restigation	, in my o	pinion, death or	ccurred at the tim	e, date ar	nd place, and due	to the cause(s)
			To To Com	Σ	29b. Signature and title of certifier	le,	^							1 - /	
Prashant Shukla, M.O. 15 South Parke Street #400 Aberdeen M.O. 2100] State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		d.	_ , λ		30 Name and address of narrow who s	omoleted caus	a of death /Ito-	n 23a) /Tuna							,
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature			BXI		Prashant Shukle	M.O.	15 500	th Park	e Str	ret	#400 F	tberdeer	MO	21001	
Redistrar			Sta Registr		31. Date filed (Month, Day, Year)	32./R	egistrar's Signa	ature	NE)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 25,27,28a-f per me 8876,02/04/08dhb Z Vear 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month **Physician SPEIGHTS** 2008 10:00 P D. 01-INEZ /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE 3 CORAL BELL CT. OWINGS MILLS If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** 1 □ M 2 🕱 F 09-12-1921 FLORIDA Director 266-72-6082 86 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b County 10a. State 1 XYes 2 No Director MD BALTIMORE OWINGS MILLS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3 CORAL BELL CT. 21117 USA Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify: BLACK þ 3 Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 DOMESTIC HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JULIA SPEIGHTS SHERMAN WHITE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) GLENN SPEIGHTS/SON 3 CORAL BELL CT., OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ORANGE HILL CEM. 02-07-2008 MARIANNA, FL 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTIMORE, MD 21217 0 Approximate Interval Between Onset and Death 23a. - 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. 21 Thine Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions coordibuting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2 🗔 Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No Certification: To 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? s after death. 27. Manner of Death 1 Woteral 5 ☐ Pending investigation 1 ☐ Yes 2 No 09/04/2007 Unknown M Subject fell 2 X Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Coral Bell Ct. Owings Mills, MD 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 9 Sidewalk To the Hospital within 24 hours at To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signate and title of certifier 10059181 1/30/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jareny Borron 702 wyoth 2121

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Darkin. permit. Pa Departme Important any injury		21. Signature of F	uneral Service Lice		ams		Cremation 299 Fred	ss of Facility Societ erick Ro	y of Maryl ad,_Baltin	more,	Inc. MD	21228 Approximate
box	Examiner	Immediate Cause disease or conditive resulting in death) Sequentially list or it any, leading to it cause. Enter Und Cause (Disease of that initiated even resulting in death)	(Final on	b. Due to (or		quence of):						
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Division or Vital Records, P.O. BOX 05/00. To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur	Certification:	27. Manner of De 1 Natural 2 Accident 3 Suicide 4 Homicid	5 Pending investigat 6 Could no determin	ation 28e. Place of building	, Day Year) of injury - At g, etc. (Spe	home, farm	M 1	□Yes 2□No ce	28f. Location (S City or Tou	Street and vn, State)	Number or i	Rural Route Number,
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State of Maryland / Department of Health and Mental Hygiene

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7		2	Union Memoria			Baltim			N/A	
	Funeral Director		213-26-8380	ex 7. Age □ M 2 KF	76	nday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day	9. Bir Co 5-1931	thplace (State or Foreign ountry) In
	and w	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Maryl f sho ied a	ţō	MD N	′ A	Balt	imore				1X Yes 2 No
	the 28a	Director	10e. Street and Number		Darc	10f. Zip Code		1	10g. Citizen of What Co	ountry?
	h with		1803 E. 33rd S	Street		21218			USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 X I If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whi Specify: B	te, etc.
21215-0036	2 hour	ted	15. Decedent's Eq	ucation	16a. I	Decedent's Usual Occup	oation	rkina	16b. Kind of Business	/Industry
215	hin 72 e. an "na Medi	Completed	(Specify only highest gra	de completed) College (1-4or 5	i+)	(Give kind of work done life. DO NOT use retire	during most of wo	E	Baltimore	City
2	ed wit giene er tha t, the	Con	12th grade N	Master's		Teacher			Public S	chool
Maryland	be file d oth event	Be	17. Father's Name (First, Middle, Last)						Maiden Surname)	
Уa	ould Men Marke	2	Johnnie Douglas		106	Mailing Address (Street	Julia		or City or Town State	Zin Cada)
Mar	d 2 sh h and 7 Is m traum		19a. Informant's Name/Relationship (Lto, MD 2	
	1 and Healt em 2 ther		Cynthia Yancey 20a. Method of Disposition	7 - Daugi		911 Annta Disposition (Name of or other pla		Date Dal	20c. Location - City of	
altimore,	ages int of t: If it		1 ☐ Burial 2 【 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	1	y, crematory or other pla mount Cem	1 _	6-2008	Baltimor	e. MD
ij	artme ortan injur		21. Signature of Funeral Service Licer	-	Green	22, Name and Addre			F/H East	21202
Ba	permi Depar Impor any ir once.		Simetti	K. Im	es	110	l E. No	orth Ave	enue Balt	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do no	ot enter the mode of dyi	ng, such as cardia	c or respiratory an	rest,	Approximate Interval Between
1	Physician	1	Immediate Cause (Final disease or condition			hematoma	-			Interval Between Onset and Death 3 weeks
	/Medical		resulting in death)	Due to (or as	a consequence o	f):			,	
E.	Examiner		Sequentially list conditions.	U.	nonia			11		Iweek
	be sit	ine	Sequentially list conditions, if any leading to investigate cause. Enter Underlying Cause (Disease or injury	Due to lor as	a conse uence o	T.	-0	All KOICA	I EXAMINER	
	ficate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as	a consequence o	if):	TIN AR	PROVED BY MEDICA		
68760,	s be e sician buris	ial E		d			CERTIFICATION			
687	ificate g phys	edical		S					110 - 310	
P.O. Box	aw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of do Month	elivery Day Year
	es that igned b	by Pl	Part II. Other significant conditions	ontributing to death b	out not resulting in	the underlying cause gir	ven in Part I.	23e. Did to	obacco use contribute res 2 1x No 3□ F	to the cause of death? Probably 4 Unknown
or Vital Records,	w requir been si should									
Sec	e law has b je 2 sh	Completed						24a. Was	prior to	autopsy findings available completion of cause of
트	Th ate pag	Co							2 XNo 1 □ Ye	
Viit	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth	ner:	ath (Check only o		
or	Phys r this ral dii	To	1 Yes 210 Ne 27. Manner of Death	1 X Inpate 28a. Date of Inju		patient 3 DCA	4 LI Nursing	-T	dence 6 Other (Sp now injury occurred	ecity)
on	nding th. : Afte : fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Ďa	ay Year) Ir		rk?]Yes 2∐No			
Division	Attending r death. ector: After by the funer	Certification:	3 Suicide 6 Could not b	e 28e. Place of inj	jury - At home, far	rm, street, factory, office		28f. Location (S City or Tox	Street and Number or I	Rural Route Number,
Ö	al or s after al Dire	Serti	4 ☐ Homicide determined	building, et	tc. (Specify)			City of You	vn, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical (29a. Certifier (Check only one)	nysician: To the best miner: On the basis of and manner st	of examination and	, death occurred at the t d/or investigation, in my	ime, date and plac opinion, death occ	ce, and due to the curred at the time,	cause(s) and manner added and place, and d	as stated. ue to the cause(s)
	To the I within 2. To the I complet	Ž	29b. Signature and title of certifier			29c. Licen			29d. Date signed (Mo	-
1			+ C.Tran, Do	/		14.1	-243894	u	January 1	TI CUO
(5)		30. Name and address of person who Christy Tran, DO	completed cause of curion Me	death (Item 23a) (Type, Print) HOSPITAL,				
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	and I				
	Regist	ar	FEB 0 4 2008	and a find	SS ATT	Ser 1 September 1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1410 P ^M 01-31-2008 John L. Szymanski /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Hosptial Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ₹ M 2 □ F 01-29-1958 Maryland Director 220-46-7000 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐Yes 2√ No Directo Maryland Harford Forest Hill 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 108 Marshall Drive 21050 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: δ Specify: 3 ☐ Widowed 4 ☐ Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 7 is marked other than "natu traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transport 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any linjury or other traumatic evone. John A. Szymanski Mary Lou Carper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lisa Szymanski (Wife) 108 Marshall Drive Forest Hill, MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐Removal from State 02-07-2008 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licenses Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2º to Immediate Cause (Final builure Prilmency metasters Due to or as a consequence of): Physician mente disease or condition resulting in death) /Medical Examiner Leucocytosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cancer Kencel Cell metastatic Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 | Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autonsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Tothe Hospital or Attending Within 24 hours after death.

To the Funeral Director: After 1 Natural 5 ☐ Pending investigation 2 □ No 1 Tes 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only 29c. License number 29b. Signature and title of certifier D0065641 Kamed Bangaria 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BELATER 500 UPPER CHESAPEKE DRIVE BANGORIA MD-21014

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

FEB 0 5 2008

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Diane Laverne Smoot 1730M 2008 Januar /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ttospital Bultimore Agnes If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | May 17, Social Security Nonber 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Funeral 1□M 2**%**F 1948 213-52-1806 59 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Examiner must be notified at 1 Yes 2 No MD n/a Director Baltimore 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1614 S. Ellamont Street 21230 U.S.A. "natural", or items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 12 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white altimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any injury or other traumatic event, the Medical Jone. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Sewing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Martha Weaver ဥ Earl William Howard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kenneth L. Smoot/Husband 1614 S. Ellamont Street Baltimore MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place)
West Arundel Crematory 20a. Method of Disposition 20c. Location - City or Town, State February 1 ☐ Burial 2 ACremation 3 ☐ Removal from State 22. Name and Address of Facility
Ambrose Funeral Home of Lansdowne
Ambrose Funeral Home of Lansdowne
Party Hammonds Ferry Rd. Lansdowne
Shock, or heart failure. List only one cause on each line. 2, 2008 Odenton, Maryland Approximate Interval Between Onset and Death Myocardial Intertan disense **Physician** soro narmy disease or condition resulting in death) /Medicai Due to (or as a consegrence of) Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Neferstatic 2 No 3 Probably 4 Unknown Dhera decular 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an funeral director, page 2 s certificate has autopsy performed Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident hours after death uneral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only within 24 one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) FEB 05

223

CATON

AlAMOSE 32. Registrar's Signature 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



MP

21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

arissa Stambe		31ate 1- For State Registrar	e of Maryland / Depa Ce.	rtificate of		Wertar rry	Reg	No. 20	08 0300
Physici	an/	1. Decedent's Name (First, Middle,L.				. 2	2. Date of Death Month I February 4,	Day Year	3. Time of Death 0104 hrs
edical Exami	ner	Clarissa Stamb	PETGET ive street and number)	- 4	lb. City, Town, or Lo	ocation of Death	February 4,	4c. County of Dea	
		4000 N. Charles St. Apt.			Baltimore				
Funeral Director		111-09-2121	Sex 7. Age (In yrs. 95	last birthday) Yrs	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Birth 11–19–1	1Fore	Birthplace (State or eign Country Hungary
any		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Locati	on				10d. Inside City Limits
and show nce.	or	MD		Baltimo:	re				1 X Yes 2 No
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Higgene. It is marked other than "natural", or items 23a or 28a-f show any traumatic event, the Medical Examiner must be notified at once.	Director	4000 N. Charles	St., Apt. 401		10f. Zip Code 21 21 8	}	10g	Citizen of What Co	
r death with or items 2:	uneral	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Ever in L Armed Forces? 1 Yes 2 X No	J.S. 13. Wa	s Decedent of Hispa es, specify Cuban, I	anic Origin? (Spe Mexican, Puerto F	ecify Yes or No- Rican, etc.)	White, etc.	erican Indian, Black,
s after iral", o	by F		of If Yes, Give Year or Dates:		Yes 2 X No		ork done	Specify: Ш	nite
2 hour "natu LExan		15. Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or 5+)		ost of working life. I			TOD. KING OF BUSINES	Simulatry
ID 21215-0036 should be filed within 72 hours after and Mental Hygiene, "7 is marked other than "natural", natic event, the Medical Examiner.	Completed	12			Homema				Home
15-C	ம	17. Father's Name (First, Middle, La Sandor Kosze	,		118	3.Mother's Name (witten <u>ber</u>	5
212 buld be I Ments mark ic even	To B	19a. Informant's Name/Relationship		19b. Mailing	Address (Street			er, City or Town, Sta	
MD nd 2 sho alth and m 27 is	Ì	Petra Vance/Da			Cavesdale			11s, MD	21117
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and I Important: If item 27 is ninjury or other traumatic		4 Donation 5 Other Spec	Removal from State Hi				5/2008	Towson,	·
Balti permit. Departr Import injury		21. Signature of Funeral Service Lic	Pudu	10	Name and Address of SO York R	ld., Tows	son, MD	21204	l Home, Inc.
Physician		23a. Part I. Enter the disease, or confailure. List only one cause on		h. Do not enter t	he mode of dying, s	uch as cardiac or	respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
Maical Examiner		Immediate Cause (Final disease or condition resulting in death)	Atherosclerotic Cardio		ease				Death
		Sequentially list conditions,	b.	O1).				_ ^	
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence c.	of):					
x 68760, h certificate be executed tending physician and use as the burial - transit	l Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence d.	of):					
60, te be execut ysician and burial - trai	edical	UNPENDED	AMENDED						
68760, certificate be nding physic se as the bur		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pre		etal death 3	Ectopic pregnar	ncy	23d. Date of deliver Month	very Day Year
that the death certifical ned by the attending phe detached for use as the	Physician/N	past 12 months? 1 Yes 2 No 9 Unkno	4 Pregnant at time of d	looth -	ther (Specify)				1
the death or y the attenry the decrus	Phys	Part II. Other significant condition	9 _ DIIKIOWII	resulting in the	underlying cause giv	ven in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
P.O es that t igned by	by]			, , ,		1 Yes	2 No 3 F	Probably 4 🗹 Unknown
rds, requir been s	Completed	M					24a. Was a autops		autopsy findings available to completion of cause of
eco he law ate has	omp						perform 1 Yes 2	ned? death	Yes 2 No
al R ian: T certific ctor, p	Be C	25. Was case referred to medical examiner?				of Death (Check o			
n of Vital Records, P.C. ding Physician: The law requires that L. After this certificate has been signed funeral director, page 2 should be dete	2	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2	ER/Outpatient				Residence 6 🗸 Ot	her: Scene
	Certification:	1 ✓ Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	Zob. Time of		es 2 No		•······,•···, •••••···	
Division tal or Attendi rs after death. al Director: A	ficat	2 Accident Investig 3 Suicide 6 Could n	28e Place of Injury - At I	home, farm, stre	et, factory, office bu	ilding, etc.	28f. Location (S or Town, St		Rural Route Number, City
Div spital or sours afte neral Dir	Cert	4 Homicide determi	ned (Specify)			1			
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Physone) 2 Medical Examin	ician: To the best of my knowle ner:On the basis of examination and manner stated.	dge, death occu and/or investiga	rred at the time, dat tion, in my opinion,	te and place, and death occurred at	due to the cause t the time, date a	nd place, and due to	the cause(s)
F » F »	Me	29b. Signature and title of certifier	α		29c. License			29d. Date signed (
		Moline Brass	ell MY		O.C.N	/I.⊏. 		February 4, 20	
3		30. Name and address of person wh Melissa Brassell, MD	o completed cause of death (Itel Assistant Medical Exam		Penn Street, Ba	altimore, MD	21201		
S Regis	tate trar		32 Registrar's Signa	ture	N. C.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #10f& 1 Gale of Maryland / Department of Health and Mental Hygiene 2 0 0 8

Amend Items 28a-f per me, g876, 02/04/08dhb eath

Reg. No. Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Frederick Stern 27 1442 0. 08 1 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Margland Medical Center 5. Social Security Dumber Baltimore City If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. January 23 1920 Diedorf, Germany 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 ☐ M 2 ☐ F 215 16 0337 88 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar," or items 23 a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anne. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐Yes 2☐No Director Baltimore Maryland Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 111 Lyndale Avenue 21221 21236 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. Specify: þ 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Electrical Engineer Elementary/Secondary (0-12) College (1-4or 5+) Bendix Corp. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Gottfried Stern Caroline Erk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura C Wilson (Daughter) 2120 Poplar Road Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ty Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gardens of Faith Cem. January 31 2008 | Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home Inc MA 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respirato Fa

Due to (or as a consequence of): Physician Failure /Medical Examiner Stroke Sequentially list conditions, if the leading to in neglect cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICA Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760 the attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 2 No 3 Probably 4 Unknown 1 🗌 Y*e*s Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation Injury 1 ☐ Yes 1/20/05 within 24 hours after death To the Funeral Director: TOWA 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as latted.

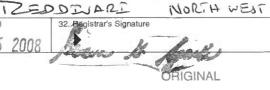
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 18235 1127/08 Name and address of person who completed cause of death (Item 23a) (Type, Print) Street, Bathmere, MD 8 Greene 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 04 2008 FB Registrar

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

FEB 05



MID

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

29c. License number

D0066357

29d. Date signed (Month, Day, Year)

31 2008

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29b. Signature and title of certifier

VENKA: A

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-00839 State of Maryland / Department of Health and Mental Hygiene Patrick H. Shomo Certificate of Death 1- For State Reg. No Registra Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day January 30, 2008 1300 hrs Patrick Η. Shomo Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Wicomico 112 Evans Place 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** oreign Min Months Davs Hours CountryPennsylvania Director 210-44-1981 55 July 12, 1952 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Maryland Wicomico Salisbury 28a-f show s 23a or 28a-f show notified at once. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 112 Evans Place 21804 USA 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolother than "natural", or items the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married Yes Specify: 4 X Divorced White If Yes, Give Year Yes 2X No specify: Widowed ş 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) 72 Baltimore, MD 21215-0036 Pages 1 and 2 should be filed within a ment of Health and Mental Hygiene. fant: If item 27 is marked other than or other traumatic event, the Medica 12 Carpenter Construction 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harvey M. Shomo Verna A. McComsey Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 Michael Shomo/Brother 444 Windy TorRoad Bird-in-Hand, Pennsylvania 17505 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State permit. Pages
Department of
Important: I Hilltop Service Corp. 2/2/08 TowsonMaryland Donation 5 Other Specify 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licensee lon 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Madical Death Contact gunshot wound of head Immediate Cause (Final disease tamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Er ter Ur denyl ig Causa Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical X UNPENDED the attending physician red for use as the burial ##ENDED7,28a-f, perME,g876, 2/28/08 TT Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. o Yes 2 V No 3 Probably 4 Unknown þ Records, P. Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? certificate has 1 🗸 Yes ✓ Yes 2 26 Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: Division of Vital æ Other: Hospital: Nursing Home 5 Residence 6 V Other: Scene ER/Outpatient 3 this (Inpatient 2 ٩ 1 🗸 Yes 28d. Describe how injury occurred After t 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27, Manner of Death Certification: Natural 1 Yes 2 X No subject shot self Pending death. Fnd 1/30/2008 | Fnd 12:40 pm Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be hours after 3 X Suicide 112 Evans Pl. Salisbury, MD (Specify) found; private dwelling To the Funeral 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 24 Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number January 31, 2008 O.C.M.E. Was 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Ling Li, MD Assistant Medical Examiner 31. Date filed (Man

DHMH 17 Rev 1/2001

Registrar

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2008

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			for State Registrar	State of Marylan		rtment of H tificate of L		ental Hyg	jiene leg. No. 20	08	03012
	Physici		Decedent's Name (First, Middle, Last)	Charles J	oseph	Stader,	Jr.	2. Date of Dea Month Februa:	th Day	Year	3. Time of Death 6:35 A M
	/Medic Examin		4a. Facility Name (If not institution, give str	eet and number)		4b. City, Town, or	Location of Death	T CDL uu.	4c. County		0.33 A
			2016 Frames Road			Dund	dalk		Balt	imor	e Co.
I	Funeral Director		214-56-0069	7. Age (In yrs. I. 58	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 1:	Year) 2,1949	Counti	ace (State or Foreign ry) yland
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	ation				10	Od. Inside City Limits
	Maryi f sho ied a	or	Maryland Baltin	ore				Dundal	l _z		1 ☐ Yes 2 ZNo
	28a-	Director	10e. Street and Number	1016	-	10f. Zip Code			l0g. Citizen of W	hat Count	rv?
	h with	al D	2016 Frames Road			21222			United	Sta	tes
	ems 2	Funeral	11. Marital Status	. Was Decedent Ever in U.S Armed Forces?	S. 13. W	Vas Decedent of His	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No-	14. Race	- America	
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy fijury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1940 —		☐ Yes 2⊠ No		nicari, etc.)	Specify:	, White, e	White
ה ה	72 ho natur lical I	Completed	15. Decedent's Educa (Specify only highest grade of	tion	16a. Deced	ent's Usual Occupa	ation uring most of working	200	16b. Kind of Bus	siness/Indu	ustry
N	ithin 7 ne. nan "I	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired)		ng			
N	led willygier		12 Years		Ta	nk Tender			Lowrey		ss Co.
and	be fi	Be	17. Father's Name (First, Middle, Last) Charles Joseph St	ador Sr			18. Mother's Name	, ,	Maiden Surname Heinbau	*	
Ž	hould d Me mark maric	户	19a. Informant's Name/Relationship (Type	· · · · · · · · · · · · · · · · · · ·	10b Mailing	Address (Street o	nd Number or Rura				0-1-1
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ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Ren	0/	ace of Dispos emetery, crem	ition (Name of natory or other place	p) D	ate	20c. Location - 0	City or Tow	vn, State
Dalillo	Pag ment ant: I		4 □ Donation 5 □ Other (Specify)	1	ltop-S	ervice Co	orp. 2/7/	2008	Towson,	Mar	yland
201	ermit.		21. Signature of Funeral Service Licensee		22. D1	Name and Address	s of Facility Funeral I	Home of			
_	Q D E 8 0		July 9 Jone		79	22 Wise 2	Ave. Dun	dalk, M	aryland	212	222
		5 V	23a Part1. Enter the disease or complica shock, or heart failure. List only one	tions that caused the death cause on each line.	. Do not ente	r the mode of dying	g, such as cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Maliquant	Fibro	rus Hist	rocy ter	na			0 marths
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-3		er	Sequentially list conditions, if any leading to immediate	Due to for as a consecu	ence of):						
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of de 9□Unknown	ath 5∐	Other (specify)					74)
٢,	s that ned b e deta		Part II. Other significant conditions contri	buting to death but not resul	ting in the und	derlying cause give	n in Part I.	23e. Did to	bacco use contri	bute to the	e cause of death?
corus,	en sig	ed by	Cardiac ischemi	a				1 🗆 Y	es 2 No	3 ☐ Proba	ıbly 4 ∐Unknown
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<u>ב</u>	cian: ertific ctor,	Be (25. Was case referred to medical examiner?				26. Place of Death				
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	ospita hours unera ly fille.		29a. Certifier Check only 27 Medical Examine	ian: To the best of my know	ledge, death	occurred at the time	e, date and place, a	and due to the c	ause(s) and mar	iner as sta	ited.
	the H iin 24 the Fu	ledical	one)	r: On the basis of examinati and manner stated.	on and/or inve			ed at the time, d	late and place, a	nd due to	the cause(s)
	with con	Σ	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed	(Month, D	ay, Year)
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	2, ,		30. Name and address of person who comp		23a) (Type, P	rint)	Avenue	AIII	Ro 14	·wore	MO 21224
162 16	Sta		31. Date filed (Month, Day, Year) FFR () 5 2008	32. Registrar's Signatu	re	9		,	Oct (I)		1
	Registra	ir	FFB 0 9 4000	A STATE OF THE PARTY OF THE PAR							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year NELLIE VIRGINIA SCOTTEN /Medical **FEBRUARY** 2008 19:02 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 103 Cooley Mill Road Havre de Grace Harford 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2√2 F Director 215-34-9805 West Virginia Jan. 22, 1925 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 Yes 2 No Directo Maryland Harford Havre de Grace 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 103 Cooley Mill Road 21078 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify þ If Yes, GIVO Year or Dates: 3 Widowed 4 Divorced Specify: White natural Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental George A. Taylor Lillie Alice Rose ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Department of Health Important: If item 27 any injury or other to once. 27 Patricia V. Buchanan/ Daughter 103 Cooley Mill Road, Havre de Grace, Maryland 21078 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion UMC Cemetery 2-7-08 Bel Air, Maryland f Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ardiac arrhythmia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner oronary Sequentially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine law requires that the death certificate be executed lomy the burial-tra Due to (or as a consequence of) Box 68760. SIP valve replacement as IF FEMALE: esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 mo 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 Other (specify) P.0. ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by been signe should be c 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform 1∐ Yes 2 3 No funeral director, 25. Was case referred of medical Be 26. Place of Death (Check only one) To Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐Other (Specify) this 27. Man of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1 ☐ Yes 2 Accident Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide ō To the Hospital of within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) nbinde 52 0 31. Date filed (Month. Day, Year) 32. Registrar's Signature

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	Physici /Medic		Decedent's Name (First, Middle, Last) ANNA	SCHWARTZ			2. Date of Death Month FEBRUARY	Day Year	3. Time of Death 10:33 A ^M
)	Examin Funeral			. Age (In yrs. last birthda	BALT	I MORE If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12/11/1	4c. County of Death BALTIMO 9. Birth Cou	place (State or Foreign
8	Director show table	or	216-16-3012 1 M 2A F Usual Residence of Decedent 10a. State 10b. County BALTIMORE	84 Yrs.			12/11/1		MD 10d. Inside City Limits 1 □ Yes 2 No
	h with the N 23a or 28a-f st be notifi	al Director	10e. Street and Number 6501 SANZO ROAD, APT. (2	10f. Zip Code	21209	10	g. Citizen of What Cou	
3-003 0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Wish owed 4 □ Divorced 1 □ Yes, Give Year or Date	Mo	B. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: WH	
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ecords, r	equires that en signed b ould be deta	۾	Part II. Other significant conditions contributing to deat	h but not resulting in the	underlying cause give	en in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
ומו חפכו	in: The law ri ificate has be or, page 2 sho	Completed	25. Was case referred to medical			00 Bloom (Down	24a. Was an autopsy performe	prior to co death? No 1 □ Yes	opsy findings available impletion of cause of
VISION OF VI	er ding Physicie ath. I. After this cert Ite funeral direct	ation: To Be	examiner? 1 Yes 2 No Hospital: 1 Inp 27. Magner of Death 28a, Date of 1		of 28c. Injur Worl	er: 4 Nursing Ho	me 5 X Residen 28d. Describe how	ce 6 □Other (Speci	fy)
	ita or Atte	Certification:	4 Homicide determined building.	injury - At home, farm, s , etc. <i>(Specify)</i>			City or Tòwn,		
	the Hosp nin 24 hou the Fune npletely fil	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best and manner. 1 Medical Examiner: On the basis and manner.	is of examination and/or	investigation, in my o	pinion, death occur	red at the time, dat	te and place, and due t	to the cause(s)
*	No. No.	2	29b. Signature and title of certifier		29c. License <i>D</i> 3		290	Date signed (Month,	Day, Year)
3	Α,		30. Name and address of person who completed cause of the first state of the state	135 Smit	e, Print)	3974 BA14 A	2/2/1	U 9	
	Sta Registra		31. Date filed (Month, Day, Year) 32. Reg	istrar's Signature	nde				

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DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 01 Year 2008 30 10:55A M 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Crofton Convalescent Center Crofton 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-20-1922 Birthplace (State or Foreign Country) 1 □ M 2 🗓 F Months Days Hours Min. 85 GA 265-18-2446 Usual Residence of Decedent 10c, City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2XNo Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 Woods Avenue 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel Webster Tootle Annie Elizabeth Thompson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Marian Sullivan/Daughter 8840 Shell Road Delmar, MD 21875 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Shiloh Church Cem. 2-9-2008 4 Donation 5 Dother (Specify) Reidsville, GA 22. Name and Address of FacilitySingleton Funeral & Cremation Srv 21. Signature of Funeral Service Licensee 1 2nd Avenue SW Glen Burnie, MD 21061 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) andio Vascular Di sas if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last her resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 X No 1 Tes 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2□ No ecify)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

r 28a-f show notified at

a or

"natural", or items 23a

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examines once.

Baltimore, Maryland 21215-0036

death with

Director

Funeral

Completed by

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2

The law requires that the death certificate be executed the burial-trar physician as attending use for þ signed to page 2 certificate or Attending Physician: funeral director. After this

death.

within 24 hours after death To the Funeral Director; filled in by the

Hospital

Division or Vital Records, P.O. Box 68760

Physician/Medical Examiner Completed by Be Certification: To

IF FEMALE:

25. Was

27. Many 12

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

was case referre					26.	Place of Dea	ath (Check only one)
1 ☐ Yes 2	No.	Hospital: 1 ☐ Inpatient 2 [☐ ER/Outpatient	3□ DOA	Other: 4	Nursing H	lome 5 ☐ Residence 6 ☐ Other (Specify)
Manner of Death 1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigation		28b. Time of Injury	28c	c. Injury at Work? 1 ☐ Yes	2 □ No	28d. Describe how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of injury - At building, etc. (Spec	nome, farm, stree	t, factory, o	office		28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

29b. Signature and title of certifier

29c. License number D20108 29d. Date signed (Month, Day, Year) 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rakesh Arora, M.D. 31. Date filed (Month, Pay, Year)

14300 Gallant Fox Lane Ste. 222 32. Registrar's Signature

Bowie, MD

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Trimble Bernard Н. 1, 2008 11:01 February 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Months Days Hours 1 X M 2 □ F September 19,1930 Pennsylvania 205-22-2141 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20906 United States 3719 Gawayne Terrace 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1955—1960 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🗓 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Trade Association 5+ Executive 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) Louise McKenna John Trimble 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3719 Gawayne Terrace, Silver Spring, Maryland 20906 Jo McDonald Trimble / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 □ Removal from State February 7, 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2008 Silver Spring, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. With M01193 300 W. Montgomery Avenue, Rockville, Maryland 20850-2805 /Ewww 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multiorgan Failure Due to (or as a consequence of): Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Pneumonia Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 DEctopic pregnancy Month Year Day 5 ☐ Other (specify) 4□Pregnant at time of death 9□Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2X No 3 Probably 4 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

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23a

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death

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permit. Pages 1 and Department of Health Important: If item 27 any injury or other the

3altimore, Maryland 21215-0036

Director

Funeral

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that the death certificate be executed

Box 68760,

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Division or Vital

Physician:

Hospital or Attending

Examiner

and physician attending properties for use as the þ signed t been certificate has this funeral After death. Director:

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24 hours after on Funeral Direct

the

29b. Signature and title of certifie

31. Date filed (Month, Day,

Irina Ruban

EB

Year).

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 🗓 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 X Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation Injury 1 X Natura 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

29c. License number

1500 Forest Glen Road, Silver Spring, Maryland 20910

D0063343

29d. Date signed (Month, Day, Year)

February 1, 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death '00 PM Physician 2008 Mildred S. Thomas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Health Und Year If Under 24 Hrs. HARFORD Rehabilitation Centy If Under 1 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🔀 F 220-14-8137 29, 87 Sep. 1920 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21014 USA 2 West Ring Factory Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black. White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2X No Specify. ģ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Banking and Mental Hygie smarked other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill Health and Mental H tem 27 is marked oth Be Allen Hoffman St. Clair Virginia Cronin Taylor 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health a
Important: If item 27 is
any injury or other trau 2 West Ring Factory Rd., Bel Air, MD 21014 James A. Thomas / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 2-4-08 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signalury of Funeral Service Incenses la 50 W. Broadway, Bel Air, MD Approximate Interval Betweer Onset and Death plical s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one hause on each line. 23a. Part1. Enter the disease, or conshock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 → No 3 Probably 4 Unknown 1 □ Yes certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an perform 2 100 within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Inversing Home 5 Residence 6 Other (Specify) 1 Tyes 2 **J** 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 / Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician:

filed within 72 hours after death with

Baltimore, Maryland 21215-0036

State

Medical

3 ☐ Suicide 4 ☐ Homicide

29a. Certifier

determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mariner as stated.

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year) 0

2100

Registrar

ate filed (Month, Day, Year) FEB 0 5 2008

32. Registrar's Signature

and manner stated

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State Registrar JOHNES MI

2008

31. Date filed (Month, Day, Year)

6101 32. Registrar's Signature Charles ST TOWSON MD ZIZO4

08-00880

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Connie White State of Maryland / Department of Health and Mental Hygiene 2008 03020 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death Physician/ 1. Decedent's Name (First, Middle,Last) Month Day January 31, 2008 2018 hrs Me∹≒al Examiner Connie White c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore** 331 South Woodyear Street N/A If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Months Days Hours Director Country) APR 25 1948 218-60-5261 59 MD M 2X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No N/A 28a-f shov MD Baltimore Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho must be notified at once Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 331 South Woodyear Street USA Funera 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married 2 X No Yes If Yes, Give Year Whi te Yes 2 X No specify. Specify: 3 Widowed Divorced ρ 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Complet event, the Medical 21215-0036 Own Home Homemaker 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Buckett Be Conrad Touchard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Itimore, MD Melvin White - Husband 331 South Woodyear Street, Baltimore, MD 21223 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) Burial 2 X Cremation 3 Removal from State 2/01/2008 portant: Metro Crematory, Inc. Baltimore, MD Donation 5 Other Specify: ö 21. Signature of Funeral Service Licensee H. Williams Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical ned by the attending physician detached for use as the burial -UNPENDED AMENDED Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o. ģ ۵ 1 Yes 2 No 3 ✓ Probably 4 Unknown probable viral illness Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has performe death? Yes 2 V No certificate To the Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Hospital: 1 Inpatient 2 Other DOA Nursing Home 5 Residence 6 V Other: Scene this 1 V Yes No 28a. Date of Injury (Month, Day, Year 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 1 V Natural Yes 2 within 24 hours after death.

To the Funeral Director: Pending completely filled in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 1, 2008 O.C.M.E. Truthell mo 2 30. Name and ress of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Pamela E. Southall, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registra

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 Day **Physician** 2008 0017 Elizabeth Marie Willinger /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. Counfy of Death Examiner Franklin Sg Baltimore Hospital Genter Koseda If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, July 22, Birthplace (State or Foreign Country) 6. Sex **Funeral** ^{Year)} 1944 Months 1 □ M 2 T F Days Hours 216-80-3225 63 Director Maryland Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a, State 10d. Inside City Limits 1 ☐ Yes 2 XNo Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hyghen.

Department of Health and Mental Hyghen.

The marked other than "natural", or Items 23a or marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examiner must be a 722 Aldsworth Road 21222 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛚 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 years **Housewife** Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William John Panoni Mildred Marie Mc Cullough 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Willinger Jr. Husband 722 Aldsworth Road, Dundalk, Maryland 21222 20b. Place of Disposition (Name of 20a. Method of Disposition February 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Memorial Middle River, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 6, 2008 21. Signatur of Fungral Service Licensee Connectly Funeral Home Of Dundalk, P.A. 73/10 Sollers Point Road, Dundalk, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cidosis Physician Metabolic /Medical Due to (or as a consequence of): Examiner ARF Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner certificate be executed attending physician and for use as the burial-transit SED21,2 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed: Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No INO Hospital: 1 Inpatient ပ 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dii 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital 29a, Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FEB 0 5

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division or Vital Records,

Willinger, Elizabeth

VASILIADES, M.D

9000 Fran

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vasiliade

2008

29c. License number

20064755

29d. Date signed (Month, Day, Year) 08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month February 3, 2008 **Physician** 5:50 A M Wollschlager Theresa May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Center If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M &\\\ 219-26-2222 71 14. 1936 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show r 28a-f show notified at 1 ☐ Yes 2 X No Director Maryland | Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be 21204 USA 32 Dunvale Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: White Saltimore, Maryland 21215-0036 à 3 ☐ Widowed 4 X ivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Railroad Accounting Clerk 12 permit. Pages 1 and 2 should be file. Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatt. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha Stanley Lane ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 309 East Timonium Road, Timonium, MD. Lane-Kunz (Daughter) Renee 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Svc. Corp. Towson, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licenses 1050 York Road, Towson, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician gangrene weeks disease or condition resulting in death) /Medical DiABUTES Millows Examiner Conflictions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cerebraracolor disease 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 s 1☐ Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Waspice Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No 1 Inpatient 2 28a. Date of Injury (Month, Day 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: After 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a 뎙 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number February 3 2000 0 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 AMON J. CHARLES MO 6701 N. Charles ST PONSON MO 21204 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 200

DHMH 17 Rev 1/2001

			For State	te of Marylar	•	artment of I			iene _{eg. No.} 2 0 0 8	02021
			1. Decedent's Name (First, Middle, Last)		001	tineate or	Death	2. Date of Deat	th	3. Time of Death
	Physicia	54		inreich, S	Sr.			Februar	ry [™] 3, 20Ŭ8	7:01 PM
	/Medic Examin	_	4a. Facility Name (If not institution, give street as			4b. City, Town,	or Location of Deat		4c. County of Death	1
All I	Examin	CI	4095 High Germany D			Westmi	nster		Carroll	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 M	7. Age (In yrs.	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day Sept.	Year) Cou	nplace (State or Foreign untry) MD
	put		Usual Residence of Decedent 10a, State 10b. County	10c. Ci	ity, Town or Lo	ocation				10d. Inside City Limits
	e Maryla Ba-f sho tified at	ctor	MD Carroll	We	stminst				0g. Citizen of What Co	1 □Yes 2 No
	th with the 23a or 2 ust be no	Funeral Director	10e. Street and Number 4095 High Germany Dr	ive		10f. Zip Code 2115			ŬSA	
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show myn Injury or other traumatic event, the Medical Examiner must be notified at once.	۾	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 1 Never Married 1 Never Married 2 Never Married 2 Never Married 2 Never Married 1 Never Married 2 Never Married 2 Never Married 2 Never Married 1 Never Married 2 Never Married	s Decedent Ever in U ned Forces? Yes 2	ţ	Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Span, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify:	
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2121	filed within 7 I Hygiene. other than "r ent, the Med	Completed		lege (1-4or 5+)	1		Mechanic		Balt. Air	Coil
Maryland	12 should be filled within h and Mental Hygiene. 7 is marked other than "traumatic event, the Meg	To Be (17. Father's Name (First, Middle, Last) William Henry Weinrei	ch			18. Mother's Na Elizabe	me (First, Middle, th V.	Maiden Surname) Thompson	
lary	2 should and N is mar		19a. Informant's Name/Relationship (Type. Prin						r, City or Town, State, Z minster, MD	
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Balti	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service Licensee	gue .				uck Towso owson, Ma	n Funeral h ryland 212	
	Physician		23a. Part1. En er the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition a. resulting in death)	that caused the dea	ath. Do not en		ring, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Disset and Death
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8760,	ficate be executed physician and the burial-transit	dical Exa	that initiated events resulting in death) Last	Due to (or as a conse	equence of):					
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ds, P.	w requires that the debeen signed by the should be detached		Part II. Other significant conditions contribution	ng to death but not re	esulting in the	underlying cause o	jiven in Part I.		obacco use contribute to ⁄es 2 □ No 3 □ Pr	o the cause of death? robably 4Unknowr
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_	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying Physician: (Check only one) 2 Medical Examiner: O	To the best of my king the basis of examinating manner stated.	nowledge, dea	ath occurred at the investigation, in m	time, date and pla y opinion, death oc	ce, and due to the curred at the time,	cause(s) and manner as date and place, and du	s stated. e to the cause(s)
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	641		30 Name and address of person who complete	ed cause of death (Ite	em 23a) (Type	L CL	101 L.	·	mail.	1 21157

State Registrar

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Weinreich

Ronald Edward

			Plea	se Type or Pri							•	
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*	Physic /Medi		1. Decedent's Name (First, Middle Cleopatra	e, Last)		Wil	liams		2. Date of De Month January	Day	2008	3. Time of Death 6:20 P M
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	ne Ma 8a-f s	cto	DC		Was	shingt						1 ∑ Yes 2 □ No
	vith th	P.	10e. Street and Number				10f. Zip Code			10g. Citi	zen of What Cou	untry?
	sath vis 23e	eral	2225 Newton St	reet 12. Was Decedent	Ever in 119	3 12 1	20018 Was Decedent of H	lienanio Origin?	Conside Van ar Na		SA 14. Race - Amer	ocan Indian
936	be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Mar 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give	?		if Yes, specify Cub	an, Mexican, Pue	rto Rican, etc.)		Black, White	
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Maryland	s 1 and 2 should f Health and Mer item 27 is marke other traumatic	-	19a. Informant's Name/Relations		`	19b. Mailir	ng Address (Street Darcy			er, City o	r Town, State, Z	(ip Code)
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ore			20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation	2 □ Bomoval from State	20b. Pl	ace of Dispo	sition (Name of matory or other pla	ce)	Date	20c. Lo	cation - City or 7	Town, State
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Baltimore,	permit. Page Department of important: If any injury or once.		21. Signature of Juneral Service	Lipense -		W	2. Name and Addre Vashingto	n Funera	11 Home			
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O	Attending Ir death. ector: After by the funer	tion	1° ☐ Actural 5 ☐ Pendir 2 ☐ Accident investi	ng (Month, Da	y Year)	Injury	Wo	rk? Yes 2 □ No	20d. Describe	low injui	y occurred	
Division	To the Hospital or Attend within 24 hours after death To the Funeral Director: / completely filled in by the f	Certification:	3 Suicide 6 Could 4 Homicide determ	inad 28e. Place of Inj	jury - At hor tc. <i>(Sp</i> ec <i>ify</i>	me, farm, str	eet, factory, office		28f. Location (S City or Tox	Street an vn, State	d Number or Ru)	ral Route Number,
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	5		30. Name and address of person	who completed cause of c	death (Item	23a) (Type,	Print)	BOAL	Ston	0	AIRE	m) 20700
yje	Sta	ite	31. Date filed (Month, Day, Year)	32 Registr	rar's Signat	ure	## WC[Z	1 0 1(0)	> -100	0 ,	V ICIM-	- "300 [0]
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JANUARY 29. Year 08 07:36M **Physician** Walicki, Jr. Edward John /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Saint Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days 1XM 2□F Director Jan 15, 1941 New York 104-30-5596 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 No Director Cockeysville Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or adloal Examiner must be re USA 17 Valley Ridge Loop 21030 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ▼ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than "natu 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Mental Hygiene. 12 02 Insurance Systems Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Is marked Walicki, Sr. Edward John Pauline 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; if item 27 Is any Injury or other trace once. 17 Valley Ridge Loop, Cockeysville, MD 21030 Adrienne F. Walicki/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5 Other (Specify) 4 Donation 1/31/08 Catonsville, Maryland Metro Crematory 22. Name and Address of Facility Bryan W. Lemmon Funeral Home of Dulaney Valley Inc. Clas 10 W. Padonia Road, Timonium, MD 21093 Enter the disease, or complications that can or heart failure. List only one cause on ear sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a, Part1 Immediate Cause disease or condition resulting in death) **Physician** ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE MINUTES /Medical Due to (or as a consequence of): Examiner MINUTES RESPIRATORY FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the a detached f 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown BLADDER CANCER Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performed?

1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 ☐ Inpatient 2 K ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 29,200B D62551 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 7601 OSLER DRIVE TOWSON, MARYLAND 21206 BEAUVIOS M D 32 Registrar's Signature State Registrar 2008

DHMH 17 Rev 1/2001

the Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after of Funeral Direct within 24

Medical (Check only one) and manner stated. 29d. Date sign#d (Month, Day, Year) 29b. Signature and title of certifie (Type, Print)
1650, ORLEANS ST BALTIMORE, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 10, 2008 3:05 Norma V. Twyman Herndon Adkins Jan. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examine Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Social Security Number **Funeral** Days 1 □ M 2X F 3/23/1929 78 Washington, DC Director 578-38-2677 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 XYes 2 No Director Washington DC N/A 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number a or ns 23a must b 20011 U.S. 929 Hamilton St., N.W. Funeral 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) an "natural", or items Medical Examiner ma 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married African 1 ☐ Yes 2X No Specify: þ 3 X Widowed 4 ☐ Divorced American Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the Dept. of Navy 4 +Finance Specialist other ulth and Mental Hygid 27 Is marked other: r traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Edwin N. Twyman 2 Dorothy T. Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a 929 Hamilton St., N.W. Wash. D.C. Karen Abbott / Daughter 20011 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 0 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cem. 1/17/08 Brentwood, MD 22. Name and Address of Facility McGuire Funeral Service, Inc 21. Signature of Funeral Service Licenses Thompson 7400 Georgia Ave., N.W. Wash. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final ENDSTAGE **Physician** disease or condition resulting in death) KENAL /Medical Due to (or as a cansequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tran Due to (or as a consequence of) Physiclan/Medical the Ses ed by the attending detached for use as IF FEMALE: nse If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 Months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9□Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 0812 Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No diSEASE 24a. Was an autopsy AboUE 2 **N**No 1□ Yes OUIATION within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 1 ☐ Yes 2[**X**/No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 □ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician: the Hospital

Maryland 21215-0036

Baltimore,

one)

29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and

29d. Date signed (Month, Day, Year)

erson/who completed cause of death (Item 23a) (Type, Print) 30. Name and address of

Spring 5+ #214, 5,1.5pg. mb. 20910

State Registrar

EGUSSIE 32 egistrar's Signature 2008

			For State Registrar	amo	end 	State of	f Mar	doc yland				dealth a	nd Me	ental Hy	giene Reg. No.	200	8	0302
п	Physic	an	1. Decedent's Nam	ne (First, Midd	de, Last)							1	Date of De Month	eath Day	Yea		3. Time of Death D
	/Medi			Martin	Asant	e Appia	h			- ₁				January	10	200		11:25 P
	Examir	ner	4a. Facility Name (/	If not institution	on, give	street and nu	ımber)			4b. Ci	y, Town, o	or Location of	Death		4c. (County of De	eath	
				oten Pa) If I Inc		kville If Under 2	4 Hrs.	D-4(D)		Montg		
ľ	Funeral Director		5. Social Security N 212-15-20)50	6. Se	x M 2□F	7. Age (i	54	a <i>st birthd</i> ay Yrs.	Month	er 1 Year s Days	Hours	Min.	B. Date of Bi (Month, Day May 29,	ay, Yea <i>r</i>)	9. 5	Country	ce (State or Forei y) Chana
	pu >		Usual Residence of 10a. State	f Decedent 10b. Count			11	0c City	. Town or L	ocation	-					.	100	d. Inside City Limit
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	iter d	un-	1 ☐ Never Marr	ried 21st Ma	rried	Armed F	orces? 2 ☑ No	J 010				Hispanic Origi ban, Mexican,	Puèrto P	lican, etc.)		Black, W	hite, et	C.
336	urs af	by	3 Widowed			if Yes, G Year or I	ive			1 🗆 Yes	2 🔼 No	Specify:				Specify:	В	lack
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	/Snor	15. Decede	nt's Edu	cation)		16a. Dec	edent's U	sual Occu	pation	of workin	n	16b. Kir	nd of Busine	ss/Indu	stry
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Ë	men tant: Jury		4 ☐ Donation 21. Signature of Fi					A11	Sou1'			ess of Facility	2/02/	2008	Germ	antown,	Mar	yland
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State Registrar

31. Date filed (Month, Day, Year) JAN 22

Ira N. Brecher, M.D., DME, 2101 Medical Park Drive, Silver Spring, Maryland 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Physician Control of Death Physician Physician Control of Death Physician Phys				For State	Pleas			Marylar	nd / Dep	artmer	nt of H	lealth	and M	-	ygiei	ne2 ()	08	03030
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The state of the s	/ital	cian: ertifica ector, p		25. Was case referr examiner?	red to medical	-	loonital:				l Ot	hor						
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	n or	Phys this al dir		27. Manner of Death	n 5 ∐ Pendin	g	28a. Date	of Injury	28b. Time	of /	28c. Inju	iry at						cify)
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		To the within To the compl	Me	29b. Signature and	title of certifie	1 1	11) 11	10		2					29d	Date sign	ned (Mon	th, Day, Year)

State Registrar DALICE MARRIOTT

31. Date filed (Month, Day, Year)

JAN 1 8 2008

30. Name and address or person who completed cause of death (Item 23a) (Type, Print)

USN

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Departr	nent of Health an <i>icate of Death</i>		0000	00001
			1. Decedent's Name (First, Middle, Last)	cale or Dealir	2. Date of Dea	Reg. No. 2	3. Time of Death
	Physici		JOHN HENRY BURNHAM, IV		Month JA1	N 13 2008	8:52 P ^M
	/Medic Examin			. City, Town, or Location of D	Death	4c. County of Deat	
			NATIONAL NAVAL MEDICAL CENTER	BETHESDA		MONTG	
	Funeral		1⊠M 2□F Vrs Mc	Under 1 Year If Under 24 onths Days Hours	Min. (Month, Da	y, Year) Co	hplace (State or Foreign untry)
8	Director		NA Usual Residence of Decedent	4	32 Jan. 1	3,2008 Man	yland
	yłand yow at		10a. State 10b. County 10c. City, Town or Location	on			10d. Inside City Limits
	a-f sh	ctor	MD Anne Arundel Fort Meade				1 ☐ Yes 2 X No
	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show edical Examiner must be notified at	al Director	10e. Street and Number 8023 C Dodd Court	0f. Zip Code 2075 5		10g. Citizen of What Co USA	untry?
	ems :	Funeral	11. Marital Status NA 12. Was Decedent Ever in U.S. 13. Was Armed Forces? 13. Was	Decedent of Hispanic Origin s, specify Cuban, Mexican, F	1? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame Black, White	
36	s after	by Fu	1 ☐ Never Married 2 ☐ Married	Yes 2 No Specify:			lack
5-0036	tural	ed k	15. Decedent's Education 16a. Decedent's	s Usual Occupation		16b. Kind of Business/	Industry
داء	0	Completed	(Specify only highest grade completed) (Give kind life. DO N	of work done during most of NOT use retired)	f working		
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Maryland	d Mer marke marke	2	John Henry Burnham III 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Ac	Apry ddress (Street and Number of	vl Kelli Pi	 	in Codo)
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Ê	Page: tent o nt: If ry or		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crema		Tan. 18, 2008	Baltimore,	Maryland
Baitimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, the Monce.		21. Signature of Funeral Service Licensee 22. Na Bar 405	ranco & Sons, Gov. Ritchie	P.A. Seve	erna Park Fi	neral Home
n			23a, Part1, Enter the disease, or complications that caused the death. Do not enter the				Approximate Interval Between
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)	/Medical		resulting in death) a. EXTREME PREMATURITY Due to (or as a consequence of):	Y			
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ISION	Attending r death. ector: After by the fune	ficat	3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street,		28f. Location (S	Street and Number or Ru	ıral Route Number,
2	al or / s after al Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Tou	vn, State)	
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: After Completely filled in by the fur	Medical (29a. Certifier (Check only one) 1 CertifyIng Physician: To the best of my knowledge, death occ 2 Medical Examiner: On the basis of examination and/or investigant manner stated.				
	To the within To the Pomple	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mont	n, Day, Year)
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1	102		30. Name and address of person who completed cause of death (Item 23a) (Type, Print		TONAL NAVA		CENTER
	M		DALICE MARRIOTT LT MC USN	BET	THESDA MD 2	20889-5600	
	Sta Registr	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month EZEKIEL HENRY BURNHAM 2008 JAN 8:05 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Director NA Jan 07,2008 Maryland 3 Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ms 23a or 28a-f shov must be notified at MD Fort Meade Director Anne Arundel 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20755 USA 8023 C Dodd Court Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status NA Examiner Black, White, etc 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Ь Baltimore, Maryland 21215-0036 NA 1 ☐ Yes 2√2 No Specify: Black δ Specify: 3 ☐ Widowed 4 ☐ Divorced 'natural", Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 7.27 is marked other than " r traumatic event at Elementary/Secondary (0-12) College (1-4or 5+) NA NA ŃΑ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Henry Burnham III Apryl Kelli Pitchford ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a John Henry Burnham III/Father 8023 C Dodd Court Fort Meade, Maryland 20755 Department of Health Important: If item 27 any Injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Jan. 18, Metro Crematory Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 2008 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Homes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician EXTREME PREMATURITY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, been signe should be c Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe certificate 2 No 1∐ Yes 2**X** No Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation (Month, Day Year) 1X Natural 1 ☐ Yes death. 2 Accident 2 🗌 No after death the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical npletely (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0102201967 (VA) 01/09/08 ss of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER

Registrar

State

th, Day, Year)
JAN 1 8 31. Date filed (Month, 2008 DHMH 17 Rev 1/2001

THADDEUS D. MAMIENSKI

LT MC USN gistrar's Signature

BETHESDA MD 20889-5600

			For State Registrar	State of M	aryland		rtment of H tificate of I		Mental H	ygiene Reg. No.	2008	3 0303	1
	البيدال	4	1. Decedent's Name (First, Mic	idle, Last)					2. Date of D	eath		3. Time of Death	-
Physic /Med			Jimmy J. Ba	iley					Month 1	22	2008	3:45 AM	ĺ
	Examir		4a. Facility Name (If not institut				4b. City, Town, or		ath		4c. County of Death		
			13219 Nantuck			-11:11:1	Ocean				lorceste		
, A	Funeral Director		5. Social Security Number 236-32-0925 Usual Residence of Decedent	6. Sex 7. Ag	e (In yrs. Ia:	Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	rs. 8. Date of B (Month, D 2/16/	av. Year)	9. Birth Cou	place (State or Foreignetry) WV	7
3	at ow		10a. State 10b. Cour	ity	10c. City,	Town or Loc	ation					10d. Inside City Limits	
	Mary I-f sh fied	to	MD Worc	ester	0cea	an Cit	у					1 ∐Yes 2 ∭XNo	j
-	or 28¢	Director	10e. Street and Number				10f. Zip Code			10g. Citi:	zen of What Cou	intry?	_
1	23a c		13219 Nantuck	et Rd.			21842			US	SA .		
36	72 mours aller death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ M 3 □ Widowed 4 □ Divorce	if Yes. Give		If	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 1 No	ispanic Origin? In, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)	0-	14. Race - Ameri Black, White, Specify: W		
5-0036	atura ical E	ted	15. Deced	ent's Education		16a. Deced	ent's Usual Occupa	ation		16b. Kir	nd of Business/Ir	ndustry	7
		Completed	(Specify only high	hest grade completed)) College (1-4or 5	5+)		aind of work done of NOT use retired	•	vorking				
2	Hygiene. hygiene. other than "	S	12			Polic	e Office				w Enfor	cement	
	ital H	Be	17. Father's Name (First, Midd.	le, Last)					ame (First, Middl	e, Maiden	Surname)		
S S	the should be the and Mental strain and Mental strain stra	ဥ	Oscar Bailey	nakia (Tara Baiat)		405 14.75			ie Milan				
Z Z	th ar 7 is trau		19a. Informant's Name/Relatio Mary Bailey /				g Address <i>(Street a</i> 9 Nantuc						
က် ဦ	Hea Hea ther		20a. Method of Disposition	WITE	20b. Pla	ce of Dispos	ition (Name of	1	Date		cation - City or T		_
Baltimore,	Department of Important: If it any injury or conce.		4 □ Donation 5 □ Other			e Henl	open Crei	m. 1	/22/2008	Fra	nkford,	DE	
E E	Impo any in		21. Signature of uneral Servi	re Licensee			Name and Addres					Home	
			23a. Part1. Enter the disease,	or complications that caused	the death.						1011	Approximate	-
.0	hysician /Medical ixaminer		shock, or heart failure. List only one cause on each line.								Interval Between Onset and Death		
58/50, ficate he executed	physician and sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a conseque	nce of):							
	g ph)	ledi											
The death certifier	certificate has been signed by the aftending prector, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal d	eath 3 🗆	Ectopic pregnancy Other <i>(specify)</i>			2	3d. Date of deliv Month	rery Day Year	
Cords, P.	en signed by	þ	Part II. Other significant cond	int conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the)		
<u>\$</u>	cate has be	Completed								opsy formed2	24b. Were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of 2 No	,
VITAL	certif	å	25. Was case referred to medic examiner?	Hospital:			Othe	er.	eath (Check only				_
الم الم	rthis raldi	<u>۲</u>	1 Yes 2 No	1 ☐ Inpatie		R/Outpatient 8b. Time of	3 DCA	4 L Nursing	Home 5 ☐ Hes 28d. Describe			fy)	_
	h. Afte fune	ţi	1 ☐ Natural 5 ☐ Pend			Injury	28c. Injury Work	?ົ ∕es 2 ∐ No	Zod. Describe	now injury	occurred		
DIVISION	within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 Suicide 6 Coul		ury - At home c. <i>(Specify)</i>	e, farm, stre			28f. Location City or To	(Street and own, State)	Number or Run	al Route Number,	
e Hospit	1 24 hours	Medical C	one) 2 Medic	ring Physician: To the best of al Examiner: On the basis of and manner sta	f examinatio ated.	n and/or inv	estigation, in my or	oinion, death oc	curred at the time	, date and	place, and due t	to the cause(s)	
Tot	withi To th	M	29b. Signature and title of certif	lece	>>	zv	29c. License	number)4625	7	29d. Date	signed (Month,	Day, Year)	
BF	10+1		30. Name and address of person	on who completed cause of de	eath (Item 2	3a) (Type, P	rint) 20 oce	ANCI	PY Bu	01	Berlin	N 1402181	/
	Sta Registr	-	31. Date filed (Month, Day, Yea	2 2000 \$32. Registra	ars Signatur	re	W -						
DHMH	1 17 Rev 1/20		JAN &	U ZUUO Sleev	a li	1 190	EASC!						_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Linuary Day Physician Year Vallie Virginia Burk 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 ☑ F Months Hours West Virginia 89 Director 213-68-6688 Sept. 16, 1918 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15827 Lockwood Road 21795 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify Specify: White ð 3 ☑ Widowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than, Pages 1 and 2 should be filed withir nent of Health and Mental Hygiene. int: If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) the 8 Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Haines Estella Snyder Truman 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 Is
any injury or other trau Susan F. Shifflett - Daughter 11041 Hickory School Road Williamsport, MD 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (5 3 □Removal from State Greenlawn Mem. Park 01-26-2008 Williamsport, Maryland 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S.Conococheague St. Williamsport, MD 21795 23a. Part1. Enter vi disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ution now /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical as the l attending nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Vear 4 Pregnant at time of death 5 Other (specify) detached the 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3∏ DOA 28a. Date of Injury
(Month. Day Year) 27. Magmer of Leath filled in by the funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Certification: To

Medical

29a. Certifier

6 Could not be determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my collection death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifi

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

31. Date filed (Month, Day, Year) **JAN 25** strar's Signature

Registrar DHMH 17 Rev 1/2001

State

To the Hospital or Within 24 hours aft

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	riease Type of Fillit in Black indelible link. Elisure All Copies
Travis Timothy Barnhart	State of Maryland / Department of Health and Mental Hyg

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hom	4	\vee	\circ		~		\sim	

avis Timothy E		hart State of Maryland / Department of H 1-For State Certificate of D Registrar			2008	3 0303			
Physicia ledical Exami	ın/	1. Decedent's Name (First, Middle,Last) Travis Timothy Barnhart		2. Date of Death	Day Year	Time of Death 0627 hrs			
			City, Town, or Location of Death Clear Spring		4c. County of Death Washington				
Funeral Director			f Under 1 Year If Under 24Hrs Months Days Hours Min	—	n(MM/DD/YYYY) 9. Birth -1982 Foreign Coun	olace (State or			
d how any		Usual Residence of Decedent 10a. State	ing			0d. Inside City Limits			
e Maryland or 28a-f show ied at once,	Director	10e. Street and Number 11814 Big Spring Rd	Of. Zip Code 21722	10	g. Citizen of What Countr				
r death with th or items 23a o	Funeral D	11. Marital Status 1	ecedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto		14. Race - America White, etc.	n Indian, Black,			
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she trammatic event, the Medical Examiner must be notified at once	ρ	Elementary/Secondary (0-12) College (1-4 or 5+)	Usual Occupation (Give kind of of working life. DO NOT use ret	ired)	Specify: 16b. Kind of Business/Inc restauran				
ore, MD 21215-0036 ges I and 2 should be filed within 77 of Health and Mental Hygiene. If item 27 is marked other than ther traumatic event, the Medical	Be Completed	17. Father's Name (First, Middle, Last) Timothy Robert Barnhart	18.Mother's Name	(First, Middle, M E Eliza	Maiden Surname)				
ore, MD 21 s I and 2 should of Health and Me If item 27 is ma	입	Timothy Barnhart 11814	ddress (Street and Number or 14 Big Spring	Ra. CI	ear Sprine	g, MD			
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Specify:	cemetery 20	n.22,	20c. Location - City or To Hagersto				
		23. Port I. Enter the disease, or complications that caused the death. Do not enter the	e and Address of Facility nald Edwin Th						
Physician /Medical xaminer		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	loue of Jing, such as car acc	* respiratory.zine	ot, are any or record	Between Onset and Death			
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause							
cuted and transit	I Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.							
D, be exe sician a	Medical	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery				
Records, P.O. Box 6876. The law requires that the death certificate are has been signed by the attending phyage 2 should be detached for use as the t	Physician/M	23b. Was decedent pregnant in the past 12 months?	death 3 Ectopic pregn. (Specify)	ancy	Month Da	y Year			
ires that the signed by the lbe detache	Ē	Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given in Part I.		bacco use contribute to the 2 ✓ No 3 Proba				
	Completed			24a. Was a autops perfort	sy prior to co med? death?	psy findings available mpletion of cause of			
Vital hysician: this certi:	Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	26.Place of Death (Check Other 4 Nursi		Residence 6 🗸 Other:	Scene			
ion of Vital literating Physician: Jeath.	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury FOUND: 1 Natural 5 Pending Investigation 29a. Date of Injury FOUND: 1 Standard Pending Investigation 29a. Date of Injury FOUND: 28b. Time of Injury FOUND: 28b. Time of Injury FOUND: 30c. Date of Injury FOUND: 40c. Date	y 28c. Injury at Work? 1 Yes 2 No	28d. Describe h Subject shot	ow injury occurred self				
Division To the Hospital or Attentwithin 24 hours after death To the Funeral Director:		28e. Place of Injury - At home, farm, street, factory, office building, etc. Specify Single Family Home 28e. Place of Injury - At home, farm, street, factory, office building, etc. Specify Single Family Home 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1814 Big Spring Road, Clear Spring, MD							
To the Hospital within 24 hours To the Funeral completely filled	Medical	(Chack only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.							
S	ž	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Mont January 18, 2008	h, Day, Year)			
5			treet, Baltimore, MD 212	201					
St Regist	ate rar	31. Date filed (Month AN YZ) 4 2008 32. Restrar's Signature	de						

OCME

Patricia Beavers (wife)

Gary

4 Donation 5 Dother (Specify) 21. Signature of Juneral Service Licenses

1 ☐ Burial 2X Cremation 3 ☐ Removal from State

20a. Method of Disposition

23a. Part1. Enter the dis Immediate Cause (Final

· Diabetes me

2 ☐ Accident

3 ☐ Suicide

29a, Certifier

4 Homicide

Geralil

31. Date filed (Month, Day,

6 ☐ Could not be

Department of Health Important: If Item 27 any injury or other to once. **Physician** /Medical

Examiner

physician and s the burial-trans attending pl After this

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

after death.

filled in by the

Division or Vital Records, P.O. Box 68760,

Examine Physician/Medical þ Completed Be Certification: To Medical

23a. Part. Entre de disease, y complications triat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Immediate Cause (Final disease or condition	_a. Ischemo		Onset and Death Uears						
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown 23d. Date of deliving the following specific pregnancy becomes a contraction of the following specific pregnancy become a contraction of the following specific pregnancy becomes a contraction of the following specific pregnancy beco									
Part II. Other significant conditions			_	23e. Did tobacco use	contribute to the cause of death?				
· Congestive Heuri	- Fallure .	Memon		1 □ Yes 2 □ N	No 3 Probably 4 ☐ Unknown				
Congestive Heart Fallure • Memouria 1 yes 2 No 3 Probe Diabetes mellitus T2 • SIP Left Lower Lung Resection for Lung Cancer Alland Penn Tarks 22 1 Peripheral Vascular performed? Penn Tarks 22 1 Peripheral Vascular									
· Abdominal Pains.	- Ischemic Bou		Disease	performed? 1□ Yes 2⊠No	death? 1 □ Yes 2 🕱 No				
25. Was case referred to medical examiner?			26. Place of Dea						
1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3□ [DOA Other: 4 Nursing H	ome 5 ☐ Residence 6 ☐	Other (Specify)				
27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury of					

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Gerald P. Sterner, MD 19 Chesapeake Beach Road, East POBox 929 Owings, MD

29c. License number

D17245

3608 Cox Court

22. Name and Address of Facility

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lee Crematory

2008

Calvert

USA

P.G. County Gov't

20c. Location - City or Town, State

Owings, MD

Clinton, MD

28f. Location (Street and Number or Rural Route Number, Cify or Town, State)

January 22, 2008

20736

Lee Funeral Home Calvert, PA

16b. Kind of Business/Industry

Murphy

Huntingtown, MD 20639

Jan 24

2008

8125 Southern Maryland Blvd.

14. Race - American Indian,

White

4c. County of Death

1900

9. Birthplace (State or Foreign

Washington, DC

10d. Inside City Limits

1 ☐ Yes 2XXXIo

State Registrar DHMH 17 Rev 1/2001

RW

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

32. Registrar

P. Sterner M. D.

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra's Signature

Schlaeges

31. Date filed (Month, Day, Year)

D16823

Cheopeale Beach MD 20732

1-21-08

Registrar

State

31. Date filed (Month, Day,

Year)

2008

22

Registrar's Signature

32

		•	For State Registrar	Otate of Man	•	ertificate of			Reg. No.	00	00	
			Decedent's Name (First, Middle, La	st)				2. Date of Do	eath Day	Year	3. Time	of Death
	Physicia /Medic		Peter Thomas E	renza				Januar	ry 19,	2008	9:	30 a ^M
	Examin	_	4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	or Location of De	ath		nty of Death		
			2226 Nees Lane			Silver				gomery		
	Funeral Director		170-26-5961	Sex 7. Age (1 18☑ M 2□ F 75	In yrs. last birthd Yrs	Months Days	If Under 24 H Hours Mi	in. (Month, D	7, 1932	Cour	olace (State otry) nsylva	e or Foreign ania
	pur *	}	Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town o	Location				1	0d. Inside	City Limits
	is 1 and 2 should be filed within 72 hours after death with the Maryland of Heelth and Mental Hygiene. Item 27 Ie marked other than "netural", or iteme 23s or 28s-f show other treumatic event, its Medical Examinar must be notified at	Director		lontgomery		Silver Spr	ing		40- Civi	of Wills of Cours		es 2 🛣 No
	or 24	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen		itry !	
	ath w	rai	2226 Nees Lane	12. Was Decedent Ev		20905	dispanie Origin?	(Specify Ves or N		SA Race - Americ	can Indian	
	ter de Item	Funeral	11. Marital Status 1 ☐ Never Married 2€ Married	Armed Forces?	BI III 0.3.	Was Decedent of I If Yes, specify Cub	an, Mexican, Pu	erto Rican, etc.)		Black, White,		
36	urs aff	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 1	958-65	1 ☐ Yes 2 ☑ No	Specify:		Spe	cify: Whi	ite	
21215-0036	2 hou	ted	15. Decedent's E	ducation	16a. De	cedent's Usual Occupive kind of work done	pation	working	16b. Kind o	Business/In	dustry	
215	thin 7 e.	Completed	(Specify only highest grant Elementary/Secondary (0-12)	College (1-4or 5+)	- lii	e. DO NOT use retire	nd)					
	ygien Ferth	Con		4	Ap	plied Phys				ohns I	lopki	ns
nd	be file d oth	Be	17. Father's Name (First, Middle, Last					_{lame (First, Middl} Kloswick		rame)		
Z	ould Men Darks	2	Peter Thomas Bre		105 14	ailing Address (Street				en State Zir	Code)	
Maryland	ind 2 should be filed within in and Mental Hygiene. 127 le marked other than " is treumatic event, I'm Mes		19a. Informant's Name/Relationship		190. M			Silver	Spring,	MD 20	0905	
Baltimore,	permit. Peges 1 and 2 Department of Heelth a Important: If Item 27 Item on injury or other tre		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Domoural from State	 Place of D cemetery, 	sposition (Name of crematory or other pla	ice)	Date an. 23,	20c. Locatio	on - City or To	own, State	1
<u><u>E</u></u>	Peg nent ant: I		4 □Donation 5 □Other (Speci	fy)	Metropo	litan Crem	natory	2008	Alex	andria	a. Vi	rginia
alt	permit. Departr Imports eny inj		21. Signature of Funeral Service Lice	nsee		22. Name and Addre Francis J	ess of Facility Colli	ns Funer	al Home	Inc.		5
00	807 2 9		James 2	1000		500 Unive	rsity B	lvd. W.	Silver		Approxim	2090
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	pplications that caused to one cause on each line.	le death. Do not	enter the mode of dy	ing, such as card	liac or respiratory	arrest,		Interval I	Between nd Death
	Pnysician		Immediate Cause (Finat disease or condition	a Small-Cel	1 Lung	Cancer					1 ye	ar
	/Medical Examiner		resulting in death)		consequence of)							
	Laminer	_	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of)							
	ed isit	nine	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dae to (or 23 2 t	consequence on							
	cate be executed physicien and the burial-transit	xan	that initiated events resulting in death) Last	CDue to (or as a	consequence of)							
9	sicien buris	aiE		d								
68760,	tificate ng phy: as the	Aedicai Examiner										
Вох	The law requires that the death certificate be executed ate has been signed by the ettending physicien and bage 2 should be detached for use as the buriat-transit		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2		3 □Ectopic pregnanc	24		23d.	Date of deliv	-	
Ď.	death e ette	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at tir		5 Other (specify)	-y 			Month	Day	Year
P.0	es that the death cer igned by the ettendin be detached for use	by Physician/I	9 Unknown	9□ Unknown								
	as tha gned be de	by Р	Part II. Other significant conditions	contributing to death but	not resulting in th	e underlying cause g	iven in Part I.		tobacco use o	/	,	of death? □Unknown
Records,	w require been sig							- '-]Yes 2□N			
ပ္ပ	as be	pie						24a. We	is an 24	b. Were auto prior to co	opsy findin ompletion	igs available of cause of
E	The ate h page	Completed							10rmed? 2 No	death? 1 ☐ Yes	2□ No	
Vital	clan: ertific ector,	Be	25. Was case referred to medical examiner?	Hamital:		10		Death (Check only				
of	Physician: this certific ral director,	10	1 ☐ Yes 2 🗹 No	Hospital: 1 Inpatient		Illent 3 DOA	4 🗆 (4013)(1	g Home 5 Re	sidence 6 e how injury or		fy)	
Ë	5 1 2	Certification:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	Year) Zoo. Inju	ry Wo	ork? ∃Yes 2⊟No	200. 0000110	5 11 5 11 11 15 15			
Division	Attending r death. ector: After by the fune	icat	2 Accident investigate 3 Suicide 6 Could not	De Dtees of Injure	/ - At home, farm	, street, factory, office		28f. Location	(Street and N	umber or Rur	ral Route I	Vumber,
j	after Direction by	ertif	4 ☐ Homicide determined	building, etc.	(Specify)	, 50.000, 120.00, 7		City or T	own, State)			
_	To the Hospital or Attendit within 24 hours after death. To the Funerel Director: Al completely filled in by the fu	edical C	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of e	xamination and/	death occurred at the tor investigation, in my	time, date and pl opinion, death o	ace, and due to the	e cause(s) and e, date and pla	manner as ce, and due	stated. to the cau:	se(s)
	thin 2 the mplet	Med	one) 29b. Signature and title of certifier	and manner state	eu.	29c. Licer	nse number		29d. Date si	gned (Month	Day, Yea	ır)
			· CBC				139		Janua	my 2	184	2008
	741		30. Name and address of person who Clement Knight,			rpe, Print) atuxent Pl	cwy., Co	olumbia,	MD 2104	14		
	Sta	te	31. Date filed (Month, Day, Year)	32 egistrar								
	Regist			.008 Mague	, K	best						

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician JANUARY 18, 2008 ALLEN JAY BLOOM 12:40 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7804 FAIRFAX ROAD BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 08/28/1935 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 X M 2 □ F CALIFÓRNIA Director 579-42-5613 72 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show notified MARYLAND MONTGOMERY BETHESDA 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n 20814 USA 7804 FAIRFAX ROAD Funeral items ; 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 Is marked other than "natural"; or Ite 1 Yes 2 Notes 1 Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 2 X No 10 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE þ Specify: 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than the M Elementary/Secondary (0-12) College (1-4or 5+) 12 EXECUTIVE VICE PRESIDENT CIRCUS 7 Is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARRY BLOOM PEARL SINGER ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUSAN BLOOM - WIFE 7804 FAIRFAX ROAD, BETHESDA, MARYLAND Department of Health Important: If item 27 any Injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State KING DAVID MEML GDNS 01/21/2008 FALLS CHURCH, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** tu 50 3 MOS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trai Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown signed t I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy performed? death? 21410 1□ Yes 2 40 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Yes 2 7 NO 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Attending 1 v atural 5 Pending investigation Injury s after dea. ral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Hospital or hin 24 hours a the Funeral I 🕊 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 7 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9 3 361 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT S. SIEGEL, MD 2150 PENNSYLVANIA AVE, #3-428, WASHINGTON, DC 31. Date filed (Month, Day, Year) Registrar's Signature State 22 2008 Registrar

			For State Registrar	State of Maryla	nd / Depa		Health and M	lental Hyg	-	8 0304
*	Physici /Medio		Decedent's Name (First, Middle, L. Ana Merced	les Benite:	z			2. Date of Deat Month Jan . 20	, 2008 Year	3. Time of Death 0030 M
	Examir	er	4a. Facility Name (If not institution, gi Holy Cross H				Spring		4c. County of Dea	
	Funeral Director			Sex 7. Age (In yrs 1	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. {	9. Bir Co 3,1942 E	thplace (State or Foreign ountry) L Salvador
	e Maryland a-f show tified at	ctor	10a. State 10b. County MD Montgo		ity, Town or Lo Rockvi					10d. Inside City Limits 1 ☐ Yes 2 No
	h with the	al Dire	10e. Street and Number 2 Dabney Cou	.rt		10f. Zip Code 208	53	10	Og. Citizen of What Co El Salv	
920	be filed within 72 hours after death with the Maryland Hylgiene. Hylgiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub	. ,	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
Maryland 21215-0036	hin 72 ho e. an "natu Medical	Completed by	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5+)	16a. Deced (Give life. L	dent's Usual Occup kind of work done DO NOT use retire			16b. Kind of Business	Industry
21	e filed wit al Hygien other thi vent, the		3 17. Father's Name (First, Middle, Las			Homemak	er 18. Mother's Name	/First Middle &	Own H	ome
ylan	be od o	To Be	Jose Trinidad	Benitez			Floren	cia Am	aya	
	nd 2 sulth ar alth ar 27 is		19a. Informant's Name/Relationship Lilian D.Sotel		I .				City or Town, State, A	
Baltimore,	Pages 1 arent of Hearnt: If item		20a. Method of Disposition 1X Burial 2 □ Cremation 3 1 4 □ Donation 5 □ Other (Special Control of the Contro	themoval nom State	Place of Dispo cemetery, crer	sition (Name of natory or other plane e Ceran	ce)	Date	20c. Location - City or an Juan 1 1 Salvade	Town, State
Balti	permit. Pages 1 Department of H Important: If ite any Injury or ot once,		21. Signatury of Funeral Service Lice		P	HYPTE PRACTS	SR TWALDI	FUNER	AL SERVI	CE,P.A. ng,Md20910
, no	eath certificate be executed ### Amount	cal Examiner	23a. Part1. Enter the disease, or cor shock, or hear failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Anoxic er Due to (or as a conser C. Pneumonia Due to (or as a conser Due to (or as a conser	ncepha quence of): ve she quence of):	thy	ng, such as cardiac c	or respiratory arre	est,	Approximate Interval Between Onset and Death
X PX	the death certificate y the attending physi ched for use as the I	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome pf pregr 1 □Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	tal death 3□	Ectopic pregnanc	y		23d. Date of del Month	livery Day Year
ds, r	res t igne be o	þ	Part II. Other significant conditions	contributing to death but not res	sulting in the ur	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	o the cause of death?
L Kec	The law ate has b page 2 st	Completed						24a. Was an autopsy perform	v prior to	utopsy findings available completion of cause of
VII	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes	Hospital: 1 Inpatient 2	TER/Outpatien	t 3 DOA Oth	er: 4 Nursing Hor		e) nce 6 □Other (Spe	city)
JIVISION OF	in o the hospital or Attending Phys within 24 hours after death. To the Funeral Director, After this completely filled in by the funeral dir	Certification: T	27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 2 Pending investigation 6 Could not be determined	e los Place of injury. At h	28b. Time of Injury	M 1□	yat k? Yes 2 □ No	28d. Describe ho	w injury occurred	
_	e Hospita 24 hours e Funeral letely filled	Medical C	29a. Certifier (Check only one) 1X Certifying Pi	hysician: To the best of my kniminer: On the basis of examinand manner stated.	owledge, death ation and/or inv	occurred at the tile estigation, in my contract	me, date and place, a opinion, death occurr	and due to the ca ed at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)
	within To the complete	Me	29b. Signature and title of certifier	'cr_		29c. Licens D6 S	e number 5305	29	Jan . 20 , 2	
			30. Name and address of person who N. Khan MD 15	completed cause of death (Item			zer Spri	na . Mars	rland 200	110
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature	MC .			201	10

1. Decedent's Name (First, Middle, Last) 15 2008 **Physician** Joseph Α. Baker 1:45A M January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11467 Reed Circle Caroline Ridgely If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | OCT | 31 Year | 935 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 220-32-0377 72 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at show 10d. Inside City Limits Director Maryland Caroline 1 ☐ Yes 2 X No Ridgely 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 11467 Reed Circle 21660 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 72 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) d 2 should be filed with and Mental Hygien 7 is marked other the truck driver dairy industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Baker Virgie Cooper 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important; if item 27 is any injury or other trau once. Donald L. Baker, Sr./ son 11467 Reed Circle; Ridgely, MD 21660 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ridgely Cemetery 01/17/08 | Ridgely, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Fleegle and Helfenbein Funeral HOme, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lemental in the disease of the death in the disease of the disease of the disease of the disease of the death in the disease of the disease of the death in the disease of the d Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arteriociloroxi **Physician** D112712. Hear & ZAVJ. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed burial-tra Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) or Vital Records, P.O. ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 036grue 106 1 es 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of page 2 s 24a. Was an autopsy performe death? 1 ☐ Yes 2 ☐ No Drb & Still 1□ Yes Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a To the Funeral 29a. Certifier 1 Secritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 029V-30. Name and address otherson who completed cause of death (Item 23a) (Type, Print)

Frill Amminson Mb 316 Mailroad Ave 10004 122 bolds on Mb

State Registrar

DHMH 17 Rev 1/2001

R3

31. Date filed (Month, Day, Year)

32. Redistrar's Signature

6 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 03043 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** John M. Crissman 2008 9:15 A M January 16, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 6. Sex 14 M 2 ☐ F 8. Date of Birth (Month, Day, Ye Oct 21, 1 9. Birthplace (State or Foreign Country)
Illinois 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Days Hours 1935 Director 520-34-1408 72 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must he matter anong. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7708 Maryknoll Avenue 20817 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Physicist Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Crissman Vivian Matthews 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Louise T. Crissman/wife</u> 7708 Maryknoll Avenue Bethesda, MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Chesapeake Crematory 01/19/08 Beltsville, MD 4 Donation 5 Dother (Specify) 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail ine. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Subdural Hemorrhage **Physician** mo ome /Medical Due to (or as a consequence of): Examiner Complicated by Alcohol Intoxication Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy Vital 1∐ Yes 2 X No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 🕅 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) MXYes 2□ No Certification: To 0 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation Injury 1 Natural fell off cammode 1 ☐ Yes 2 No 1200 M 2 Accident Jan 2 2008 24 hours after death Pruneral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7708 MGTYKnoll Ave. Bethorda mo 208/7 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Home Medical 29a. Certifier 1 🙆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and the of cer 29c. License number 29d. Date signed (Month, Day, Year) January 17, 2008

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State Registrar 30. Name and add

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Day Year Month **Physician** 21, 2008 1536 January Sandra Gail Clark /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington Hagerstown 11218 Scarlet Oak Drive If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Sept. 30, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2**)** ☐ F 1950 57 Virginia Director 213-56-4400 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b County or 28e-f show 27 is marked other than "neturel", or items 23a or 28e-f shov treumatic event, the Madical Examitrational by notified at 1 ☐ Yes 2√ No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10f Zip Code 10e. Street and Numbe 11218 Scarlet Oak Drive 21740 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2√2 No Specify: 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hospital 11 Certified Nursing Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Elizabeth Laura Howard Thomas Elvis Arrington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health Item 27 Clifford Kerill - Son 1040 A Noland Drive Court 5 Hagerstown, MD 21740 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Importent: If it any injury or o 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 01-25-2008 Tilghmanton, Maryland 5 Other (Specify) Manor Cemetery ¹ 4 ☐ Donation 22. Name and Address of Facility Osborne Funeral Home, P.A. 21. Signature of Funeral Service L 425 S.Conococheague St. Williamsport, MD Enter le disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or havit failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardio respiratory mmediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Coronay Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Examiner Physician: The law requires that the death certificate be executed for use as the burial-transit long-term attending physician and Due to (or as a consequence of) Rheumorpid IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 menths? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funerel Director; After this certificate has I completely filled in by the funeral director, page 2 s autopsy 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 2 No Medical Certification: To 1 🗌 Yes 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Hospital or Attending 1 Natural Injury 5 Pending 1 🗌 Yes 2 No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 23, 2008 D59749 30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print) 2010 Oates Drive Suite 104 Martinsburg, West Virginia 25401 Michael Rezaian MD 31. Date filed (Month, Day, Year) strar's Signature

Registrar

State

JAN 2 5 2008

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygien@ | | | | | For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician Virginia Middlekauff Clark January 19 2008 6:15 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hagerstown Coffman Nursing Home Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 93 Maryland July 9 1914 Director 218-34-3908 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location orient: If Item 27 is marked other then "netural", or Items 23a or 28a-1 show Injury or other traumatic event, the Madical Examinar must be notified at Maryland 1 ☐ Yes 2 No Washington Hagerstown **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21742 1304 Pennsylvania Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant I fler 27 is marked other then "netural", or ite 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 White þ 3 X Widowed 4 □ Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Drug Store Business Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Virginia Weber Middlekauff Homer Middlekauff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17632 College Road Hagerstown Maryland 21740 William Clark - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1-22-08 Smithsburg Maryland permit. Page Department Importent: If any Injury o Smithsburg Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): the ettending physician Division of Vital Records, P.O. Box 68760. by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy ŏ Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No page 2 should be detached 9 Unknown 9 Unknown this certificate has been signed by 23e. Did tobacco use contribute to the cause of death? eath but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2010 terel Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Medical Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c, Injury at Work? 1 (3Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours To the Funerel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 200 Hoger Haww 1990 21740 death (Item 23a) (Type, Prjet) SH-8 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Casey House 5. Social Security Number 6	i. Sex	7 A== (In tree	la a t h i with ala s c	Rockvil If Under 1 Yea		r 24 Hrs.	O Data a		Montgor			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 18, 2008 7:01 P. M Claude Richard Carpenter January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Calvert Memorial Hospital Prince Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 03/04/1947 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6. Sex. 1₽M 2□F 7. Age (In yrs. last birthday) **Funeral** Days 60 227-62-7162 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 XNo Lusby Director MD Calvert 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number United States 793 Sandy Wash Circle 20657 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Automotive 12 Auto Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alene L. Smith Charles J. Carpenter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 793 Sandy Wash Circle, Lusby, Maryland 20657 Wanda Jean Carpenter (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metropolitan Crematory 1/21/2008 | Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each me. P. O. Box 600, Lusby, Maryland 20657 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical (or as a consequence of): **Examiner** 050 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 4.4 hours after death. attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 28 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient → ER/Outpatient 3∏ DOA 1 Yes 2 No Medical Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Director: After (Month, Day Year) Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and ganner stated. completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Jonathan Lowenthal,

31. Date filed (Month, Day,

2008 Re

Registras Signature

MD 110 Hospital Rd., Suite 310, Prince Frederick, MD 20678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Fernand Joseph Coulon January 17, 2008 8:22p 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Holy Cross Hospital Montgomery 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Months Davs Hours Min 1. M 2 □ F New York 084-01-1826 October 2. 1914 93 Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐Yes 2 TNo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 14400 Homecrest Road 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Executive Chef Marriott Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Emile Coulon Alice Rondez 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frieda Frances Coulon/Wife 14400 Homecrest Road, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jan. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cemetery 2008 Silver Spring, Maryland 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiopulmonary Arrest Due to (or as a consequence of) Res iratory Failure Due to (or as a consequence of) Myocardial Infarction Due to (or as a consequence of) End-Stage Heart Disease If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy perform

Physician /Medical Examiner certificate be executed

Physician

/Medical

Examiner

Funeral

Director

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an "natural", or ite⊞s 23a or Medical Examíner must be i

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1 and 2 should be filed will Health and Mental Hygier
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Pages '

Department of Health and Mental Hygi Important: If Item 27 Is marked other any injury or other traumatic event, t

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

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Examiner burial-trar Physician/Medical the use þ the signed by t 9 Completed page 2 certificate | director, Be ပ this After t 24 hours after death e Funeral Director: the

Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1∐ Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🔲 Yes 2 No 1 Alnpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 🔼 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my original death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year)

D65069

January 18,2008

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the Hospital or Attending

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death

in by

filled

the

Registrar

State

1500 Forest Glen Road, Silver Spring, MD 20910

and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Sirak H. Lemma, MD 31. Date filed (Month, Day, Year)

JAN

22

			1 - For State Registrar	State of IVI		epaπment o Certificate α		nd Mental Hy	/giene Reg. No 20	08	03049
Ph	nysici	an	1. Decedent's Name (First, Middle, Las	<i>'</i>				2. Date of D Month JAN •		Year	3. Time of Death
1	Medic xamin		MARTHA 4a. Facility Name (If not institution, give		INN	4b. City. Tow	n, or Location of		4c. County		4:05 PM
	.aiiiii	CI	Shady Grove Nu		ome		kville			TGOM	ERY
	neral ector		5. Social Security Number 230-40-3173 Usual Residence of Decedent	ex 7. Ag □ M 2 ½ f	e (In yrs. last birth 89 y	nday) If Under 1 Y Months Da		Min. 8. Date of Bi (Month, D Jan • 2	rth ay, Yea <i>r)</i> 24,1918	9. Birthp Coun Vir	place <i>(State or Foreign</i> ntry) ginia
yland	at		10a. State 10b. County		10c. City, Town	or Location				1	10d. Inside City Limits
he Ma	otified	Director	MD Montgo	mery	С	larksbur		4,00			1 Yes 2 No
ath with t	ust be n	ral Dir	10e. Street and Number 12832 Clarksh			10f. Zip Cod	20871		10g. Citizen of \	What Cour	itry?
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 77 is marked other than "natural", or items 23a or 28a-f show	Examiner m	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:		13. Was Decedent If Yes, specify (n? (Specify Yes or N Puerto Rican, etc.)	Blac	e - Americ ck, White, /: Bl	etc.
15-0 72 hc "natu	dical	leted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. [Decedent's Usual Od Give kind of work do life. DO NOT use re	cupation one during most o	of working	16b. Kind of Bu	usiness/Ind	dustry
vithir liene.	the Mc	Completed by	Elementary/Secondary (0-12) 8th	College (1-4or 5	i+)	Cook	tired)		Resta	ıran	t
nd:	event,	Be C	17. Father's Name (First, Middle, Last)		· · · · · · · · · · · · · · · · · · ·			s Name (First, Middle		ne)	
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	any injury or ot once,		20a. Method of Disposition ↑ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify 21. Signature Funeral Service Licen)		Disposition (Name of crematory or other Cemeter 22. Name and Act 246 N.	y 1 dress of Facility			bur	•
Physic /Med Exam	lical		23a. Part1. Enter the disease, or coords shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Ather		otic Car	dying, such as ca		arrest,		Approximate Interval Between Onset and Death Immediate
68 / 60, tificate be executed g physician and	the burial-transit	edical Examiner	Sequentially list conditions, and adding to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of						
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S, F es tha igned	e l	by P	Part II. Other significant conditions co	entributing to death bu	ut not resulting in t	he underlying cause	given in Part I.				ne cause of death?
Kecords, he law requires t has been signe	phould	eted	Dementia		D'					3 Prob	oably 4 Hunknown
age ⊐ =	page 2	e Completed	Peripheral Stroke 25. Was case referred to medical	vascular	Disea	se			psy ormed? 2 No	orior to cor death?	psy findings available mpletion of cause of
Or VITA Physician:		0 B	examiner?	Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Outp	atient 3 DOA	0.1	f Death (Check only ing Home 5 ☐ Res		er (Specifi	v)
On Or ding Phys	funeral	uo I	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day			njury at Vork?		how injury occurr		2
	completely filled in by the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injubuilding, etc	ry - At home, farn :. (Specify)	M n, street, factory, off	□Yes 2□No	28f. Location (Street and Numb wn, State)	er or Rura	I Route Number,
ne Hospit 124 hour ne Funer	letely fill	Medical (29a. Certifier 1 Certifying Phyone) Medical Exam	rsician: To the best of iner: On the basis of and manner sta	examination and/	death occurred at the for investigation, in r	e time, date and ny opinion, death	place, and due to the occurred at the time	cause(s) and ma , date and place,	nner as st and due to	ated. the cause(s)
To the within 2	dimos	Me	29b. Signature and title of certifier				ense number		29d. Date signed		Day, Year) 2008
3		-	30. Name and address of person who c	ompleted cause of de	eath (Item 23a) (T		20000		<u> </u>		2000
			Ravi Passi, M 31. Date filed (Month, Day, Year)		25 Shad	y Grove	Rd, #2	08, Rock	ville,	1D 2	0850
Re	Stat gistra		JAN 2 2 20		Signature A	porte					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year 1:10 A^M 2008 JAN 19 Chiaka Connie 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Takoma Park Montgomery Sligo Creek Nursing & Rehab 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months 1 □ M 2 🗓 F AUG 14, 1948 Virginia 578-66-2700 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Capital Heights Maryland Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 6808 Walker Mill Road 20743 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 🕅 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home Care Nurse 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bernice Cooper John D. Blunt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bernice Strayhorn/Daughter 3801 Kenilworth Ave. #405E Bladensburg, MD 20710 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State Washington, DC Mt. Olivet Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 1/26/2008 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Thibadeau Mortuary Service, P.A. 933 Gist Ave., LL Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) re brovan whave

Physician /Medical **Examiner**

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To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After

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certificate be executed

Box 68760

P.O.

Division of Vital Records.

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Certification:

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r then "natural", or Items 23e or 28e-f show the Modical Examinar must be notified at

f Hygiene.

Pages 1 and 2 should be fill ment of Health and Mental H lant: If item 27 is marked ott

permit. Pages 1 and 2 a Department of Health ar Important: If item 27 is eny injury or other trau

Funeral Director

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Completed

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filed within 72 hours after death

Baltimore, Maryland 21215-0036

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 X No

9 Unknown

27. Manner of Death 1 DNatural

2 Accident

3 Suicide

29a. Certifier

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death

3 □Ectopic pregnancy 5 Other (specify) 9 Unknown

Month Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Inknown 1 ☐ Yes 2 ☐ No

23d. Date of delivery

24a. Was an autopsy perform 1 Yes 2 No

26. Place of Death (Check only one,

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

25. Was case referred to medical examiner' 1 Yes 2 No

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Home 28c. injury at Work? 1 ☐ Yes 2 ☐ No

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

5 ☐ Residence 6 ☐ Other (Specify)

6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and matrices as section.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

29d, Date signed (Month, Day, Year)

29b. Signature and title of certifier

5 Pending

investigation

D46998 January 19,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stum Tee MD 3415 Hamulton STH1 Hyathvilly MD 20782

31. Date filed (Month, Day, Year)



State Registrar

	00595 hleen Hynn (State	or Print in Black In e of Maryland / Depa <i>Cer</i>		Health				200	8 0305
	Physici	ın/	Registrar 1. Decedent's Name (First, Middle,La					2. Dat Mo	e of Death		3. Time of Death 1755 hrs
Me >>	dical Exami		Kathleen 4a. Facility Name (if not institution, gi	Hyun Clan		lb. Citv. Tow	n, or Location o		nth [luary 21,	2008 4c. County of Deat	1
			Shore Hwy & Downes Sta			Denton				Caroline	
	Funeral Director		5. Social Security Number 6. S 214-41-5480	Sex 7. Age (In yrs. I: 15	ast birthday) Yrs.		Year If Under Days Hours	Min. S	ept	(MM/DD/YYYY) 9. Bi 30 199 Zorei Ci	rthplace (State or gn ^{ountry)} S Korea
	ž		Usual Residence of Decedent 10a. State 10b. County	110c City	Town or Locati	on					10d. Inside City Limits
	id how any		,		enton						1 Yes 2 X No
	farylan 28a-f s	Director	10e. Street and Number		<u> </u>	10f. Zip Co	de		10g	. Citizen of What Co	untry?
	h the N 3a or S		23267 Shady (216	29			USA	
	Baltimore, MD 21215-0036 sount. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene, Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Midical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Marrie 3 Widowed 4 Divorce	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No ed If Yes, Give Year	lf Y	es, specify C	of Hispanic Orig cuban, Mexican, No specify:			14. Race - Ame White, etc.	rican Indian, Black, ian
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	21215-0036 und be filed within 72 hou Mental Hygiene. marked other than "nar c event, the Medical Exs	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	stude		g life. DO NOT			n/a	
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	212 uld be Mental marke	To Be	19a. Informant's Name/Relationship		19b. Mailing	Address (er, City or Town, Sta	te, Zip Code)
	MD nd 2 sho alth and m 27 is		Robert L. Clar					Road		nton, MD	
	Baltimore, ocumit. Pages I amo Decartment of Heal Important: If item nijury or other tra		20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other Specia	Removal from State	Place of Dispos crematory or oth ly Cro	her place)		01/26		20c. Location - City of Greensbo	
	Salti comit. epartm mports ujury o		21. Signature of Funeral Service Lice				dress of Facility		hoin	Funoral	Home, PA
	_ ===:=		23a. Part I. Enter the disease, or con	mplications that caused the death	P I	eegie	mana n	eensb	De III	st MD, 2163	9 Approximate Interval
5	Physician /Medical xaminer		failure. List only one cause on	each line. a. Multiple Injuries Due to (or as a consequence of					5		Between Onset and Death
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	cuted and transit	ш	events resulting in death) Last	Due to (or as a consequence of	of):						٧
	O, be exe sician vurial -	edic	UNPENDED	AMENDED							
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Directors. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unknow	23c. If yes, outcome of pres 1 Live birth 4 Pregnant at time of down 9 Unknown	2 Fe	etal death ther (Specify		c pregnancy		23d. Date of delive Month	ery Day Year
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	e law requi e has been ge 2 should	Completed							24a. Was a autops perform	prior to med? death	
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	Vita nysicia this ce	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient	3 DO	A Other	Nursing Hor	me 5 F	Residence 6 🗸 Otl	ner: Scene
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	Division To the Hospital or Attence within 24 hours after death To the Funeral Director; completely filled in by the	Certification:	3 Suicide 6 Could no determin	ot be 28e. Place of Injury - At h		-	ffice building, e		or Town, St		Rural Route Number, City
	n 24 h n 24 h ne Fun iletely		29a. Certifier 1 Certifying Phys	ician: To the best of my knowled ner:On the basis of examination	dge, death occu	rred at the ti	me, date and pla	ace, and due to	time, date a	e(s) and manner as sand place, and due to	tated. the cause(s)
	To the within To the complet	Medical	29b. Signature and title of certifier	and manner stated.			License number	. ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	29d. Date signed (#	
		_	(mi) P				O.C.M.E.			January 22, 20	
1			30. Name and address of person wh	no completed cause of death (Iter	m 23a)		 · · -				

State 31. Date filed (Marka 2 • 4) 2008 Registrar

Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

Date filed (MAN) 2 2 2008 3 Registrar's Signature

OCME

State Registrar

ORIGINAL

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

January 14, 2008

30. Name and address of person who completed cause of death (Item 23a)

2008 6

29b. Signature and title of certifier

Tasha Greenberg MD

JAN 1

31. Date filed (Month, Day, Year)

and manner stated

Assistant Medical Examiner

gistrar's Signatu

			1 - State AXCO HEALTH DE	Pr. 1/18/08 C	on yılanı MH		rtificate of			eg. No.	UÖ	UJ	053
	Di		1. Decedent's Name (First, Middle,	Last)					Date of Deat Month	th	Voor	3. Time o	f Death
3	Physicia Medic		Ethel Dorr					,	January	$15^{\text{ay}}, 200$	8	8:47	A M
	Examin	er	4a. Facility Name (If not institution,	-				Location of Death		4c. County o			
		ш	2605 Kenhill Dr		va (In uma	lood birdhalaa i	Bowie If Under 1 Year	If Under 24 Hrs.		Prince			
	Funeral Director		5. Social Security Number 578-24-1121 Usual Residence of Decedent	6. Sex 7. Ag	82	ast birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Nov. 13	, 1925 I	Coui		or Foreign
	/land ow at		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside C	City Limits
	Man a-f sh fied	to	Maryland Prince	George's	Bow	ie						YYes	3 2 □ No
	th with the 23a or 28 ist be not	al Direc	10e. Street and Number 2605 Kenhill Dri	ive	'		10f. Zip Code 20715		1	0g. Citizen of W	hat Cou	ntry?	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ◯ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? ad 1 Tyes 2 X If Yes, Give Year or Dates:	•		Was Decedent of H If Yes, specity Cuba 1 ☐ Yes 2 X No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- America, White,		
20	72 ho natur iical I	sted	15. Decedent's (Specify only highest	s Education		16a. Deced	dent's Usual Occup	ation	ina	16b. Kind of Bus			
21215-0036	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)			during most of work d)		Own Home			
	filed Hygid Sther		17. Father's Name (First, Middle, L	ast)		Home 1	Maker	18. Mother's Name					-
lan	lid be fental rked c	To Be	Walter W. Petzo	ld				Lillian	Bullen				
Maryland	shou and N s mar		19a. Informant's Name/Relationsh	ip (Type. Print)		19b. Mailir	ng Address (Street	and Number or Rur	al Route Number	r, City or Town, S	State, Zij	o Code)	
Σ	and 2 salth a n 27 i		Joanne M. Ginge	rich/ Daugh				Drive Bow	vie, MD	20715			
ore	of He		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □Removal from State	20b. P	lace of Dispo emetery, crer	sition (Name of natory or other plac	ce)	Date	20c. Location - 0	City or To	own, State	
Ĕ	Pag iment tant: I		4 Donation 5 Other (Sp	ecify)	Ft.	Linco	oln Cemet	ery 1/19	7/2008	Brentwoo	od, 1	MD_	
Baltimore,	permit Depart Import any In		21. Signature of Funeral Service	ensee		22	2. Name and Addre	ss of Facility Rob	ert E.	Evans Fu	iner	al Hom	ie
	₽D = 40	9	200 Double States the disease are		d the death			polis Roa			715	Approxima	
		8	23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final	only one cause on each li	ne.	i. Do not em	er trie mode or dyn	ig, such as cardiac	or respiratory am	esi,		Interval Be Onset and	etween
	Physician /Medical		disease or condition resulting in death)	a Due to (or as	4	inner of)	hona	*			-		
	Examiner				a conse	erice or).						140	ear
	Maria I	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequ	uence of):							
	tificate be executed ig physician and as the burial-transit	Examiner	that initiated events	c									
9	oe exe cian a urial-	Ě	resulting in death) Last	Due to (or as	a consequ	ence of):							
68760,	cate b	edical	`	d									
.O. Box	The law requires that the death certifi ate has been signed by the attending bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	death 3	Ectopic pregnancy Other (specify)			23d. Date Mon		-	Year
Records, P.	res t igne be c	þ	Part II. Other significant condition	ns contributing to death b	out not resu	ulting in the ui	nderlying cause giv	en in Part I.		oacco use contri es 2 → No			
Reco	The larate has	Completed							24a. Was a autops perform	ned? p	rior to co eath?	opsy findings ompletion of a	available cause of
Viita	ding Physician: The n. After this certificate har funeral director, page	Be	25. Was case referred to medical examiner?	11				26. Place of Deat					
2	Physic this c	P	1 Yes 2 ₩0			ER/Outpatien		4 □ Nursing Ho	ome 5X Reside		<u> </u>	fy)	
UC	ding F	ion	27. Manner of Death 1 □ Matural 5 □ Pending	28a. Date of Inju (Month, Da		28b. Time of Injury	Wor		28d. Describe ho	ow injury occurre	ed		
Division or	Attending Physician: r death. ector: After this certifics by the funeral director, I	Certification:	2 Accident investigation inves	ot be 28e. Place of inj	ury - At ho	me, farm, str	eet, factory, office	Yes 2 □ No	28f. Location (St		r or Run	al Route Nur	mber,
á	al or safter	erti	4 ☐ Homicide determin	building, ef	tc. (Specif)	/)			City or Town	n, State)			
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical (29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best xaminer: On the basis of and manner st	of examina	wledge, death tion and/or in	n occurred at the til vestigation, in my o	me, date and place, pinion, death occur	and due to the c red at the time, d	ause(s) and mai late and place, a	nner as s .nd due t	stated. to the cause((s)
	To th To th	Me	29b. Signature and title of certifier				29c. Licens		2	9d. Date signed	(Month,	Day, Year)	
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P	DI 10		30. Name and address of person w					ne Fico i3	DW.E.	n 20	7(<	_	
	Sta	te	31. Date filed (Month, Day, Year) JAN 1 8	32. egistr	ar's Signa	ture							
		ar	X I MAJ.	/11115 MSC.a.		G A							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 5:15 A M William Robert Dickson Jan 17, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Lusby 527 Maple Way If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Months Days Director 579-86-7703 48 England Sep 13, 1959 Usual Residence of Decedent the Maryland 10h Counts 10c. City, Town or Location 10d. Inside City Limits 10a State r 28a-f show notified at show 1 ☐ Yes 2 No Director MD Calvert Lusby 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code o e filed within 72 hours after death with items 23a c 20657 U.S.A. 527 Maple Way Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. em 27 is marked other than ther traumatic event, the M **Union Painter** Painting 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental George Thomas Dickson Jr. Dorothy M. Bolter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina Dickson /Wife 527 Maple Way Lusby, MD 20657 If item 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【ICremation 3 【Removal from State Department of Important; If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 01/18/08 Alexandria, VA Metropolitan Crematory 21. Signature of Funeral Service License 22. Name and Address of Facility Glader Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Lung years disease or condition resulting in death) /Medical Due to (or as a cop equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. In the Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner requires that the death certificate be executed g physician and as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical as ding IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy 0 Month Day Year in the past 12 months? 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the a Ö 9 Unknown ۵ signed by be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy perform certificate 2 **№** No 1∐ Yes or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Division Hospital or Attending 1 XNatural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1/18/08 MD 33037 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reservoir ROAD, NU WASHINGTON DC 3800 Tyle 31. Date filed (Month, Day, Registrar Signature State Registrar

The law requires that the death certificate be executed use as the burial-tran and attending physician for use as the burial Division or Vital Records, P.O. Box 68760, cate has been signed by page 2 should be detach certificate Physician: funeral director, After this

Attending To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death.

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

"natural"

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and Mental Hygiene.

if Health and Menta Item 27 is marked

Department of I Important: If Ite any Injury or o

Physician

/Medical

Examiner

other traumatic event, the Medical

Director

Funeral

Completed by

Be

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Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

3altimore, Maryland 21215-0036

Medical

29b. Signature and title of certifier

2008

6 ☐ Could not be

29c. License number DO05 2410

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Cetturam WARKS COASTAL

HOSPICE PO BOX 1733 SALISBURY UP 21802

31. Date filed (Month, Day, Year) State 22 Registra

3 Suicide

29a. Certifier (Check only

4 Homicide

egistrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

			For State Registrar	State of Maryland		artment o		nd Mental H	ygiene Reg. No	1006	03056	
	Dharata		1. Decedent's Name (First, Middle, Li	ast)				2. Date of 0	Death		3. Time of Death	_
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7	Examir	ier	4a. Facility Name (If not institution, gi				n, or Location of D	Death		County of Dea		
			Bradford Oaks 5. Social Security Number 6.	Nursing Home Sex 7. Age (In yrs. Ia.	ot hirthday		linton ear If Under 24	Hrs R Data of S	P:	rince	George's	
	Funeral Director			1□M 2⊠F 84	Yrs.	Months Da		Min. (Month, I	7 (17)	1923	thplace (State or Foreign ountry) Guyana	,
	פ		Usual Residence of Decedent					БСРС		1745		
	anylar show	_	10a. State 10b. County		Town or Lo	ocation					10d. Inside City Limits Yes 2 □ No	
	the M	ecto	MD Prince 10e. Street and Number	George's Ox	on H				10- 00			
	with	급	5619 Dundalk	Dr		10f. Zip Coo	[®] 745		10g. Cit	izen of What Co	ountry?	
	death ms 2%	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S.	. 13.			? (Specify Yes or it	10-	USA 14. Race - Ame	arican Indian,	_
9	after or ite	Fur	1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give	1			uerto Rican, etc.)		Black, White		
003	72 hours after death with the Maryland hetural, or items 23e or 28a-f show dical Examinest be political at	d by	3 Widowed 4 Divorced	Year or Dates:		1 □ Yes 24€	No Specify:			Specify: At Am	rican- erican	
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	illed Hygid other	BeC	17. Father's Name (First, Middle, Las	0		21012		Name (First, Midd			пе	
/lar	2 should be filed within 72 hours after dea and Mental Hyglene. Is marked other than "netural; or items aumatic event, It a Medical Exami actin	To B	Charles Arlin	gton Durant			The	resa Anı	a Gr	iffi+h		
Maryland			19a. Informant's Name/Relationship		19b. Maili	ng Address (Str	eet and Number o	or Rural Route Num	ber, City o	r Town, State, .	Zip Code 20904	
	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr once.		Patricia Isaa		9 M	orning	Breeze	e Ct. S	lve	r Spri	ng, MD.	
Baltimore,	Pages 1 nent of H ant: if ite ury or ot		20a. Method of Disposition 1 Burial 2 □ Cremation 3 [☐Removal from State cen	netery, crei	sition (Name of natory or other	place)	Date	N .	ocation - City or		
Iţi	permit. Pag Department Importent: I any Injury c		* 4 □ Donation 5 □ Other (Special Service Lice		ck C	reek	1/	25/08	Was	shingto	on, DC	-
Ba	permit. Departr Importe any inju		Inolar I	10000	-	7400 Ge	oress or Facility	McGuire Ave., N	Fun w	eral S	Service 20012 ngton, DC	,
			23a. Part1. Enter the disease, or con	plications that caused the death.						wasiii	Approximate	_
	Pnysician -		shock, or heart failure. List only Immediate Cause (Final disease or condition	a. Atherosci	erot	ia Con		1 D			Interval Between Onset and Death	
	/Medical		resulting in death)	Due to (or as a conseque		ic cai	uiovas	cular D	isea	se	Years	
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-	bed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to (or as a conseque	nce of):							
	be executed sician and burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or as a conseque	nce of):							_
8760,	The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical E	(d								
9	tificate ig phys as the	ledic		_ u.								
Вох	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnand		lEctopic pregna	ncv			23d. Date of de		
O. E	at the dea by the att	Physician/Me	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of dea 9☐ Unknown		Other (specify				Month	Day Year	11.4
σ.	that the		9 ☐ Unknown Part II. Other significant conditions	contributing to death but not result	ing in the w	adarbijas sauss	enues in Best I	230 Dis	I tobacca u	s a contribute to	the cause of death?	
ds,	uires t signe Id be c	d by	Decubitus Ul			idenying cause			Yes 2	_	robably 4 []Unknown	
Sor	w requ	ete	Decapieds of	JELS				24a. Wa				_
Vital Record	The lar	Completed						— aut	opsy formed?	prior to death?	utopsy findings available completion of cause of	
ta		0	25. Was case referred to medical				26 Place of	1 ☐ Yes Death Check onl		1 🗆 Yes	2 No	-
of V	Physicien: this certific ral director.	To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ EF	VOutpatien	t 3 DOA	Othor	ng Home 5 Re		6 □Other (Spe	cify)	77
			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. ir	nury at Vork?	28d. Describe	how injur	y occurred		
Sio	be be	catl	2 Accident investigatio 3 Suicide 6 Could not b	n l			☐ Yes 2 ☐ No					
Division	를 다 하는 다	Certification:	4 Homicide determined		e, farm, str	eet, factory, office	CB .		(Street and own, State		ural Route Number,	
_	Hospitel		29a. Certifier 1X Certifying Pt	nysician: To the best of my knowle	edne death	Occurred at the	time date and n	lace, and due to th	e cause(s)	and manner as	stated	
	To the Hos within 24 h To the Fur completely	edical	(Check only 2 Medical Example)	miner: On the basis of examination and manner stated.	n and/or inv	estigation, in m	y opinion, death o	occurred at the time	e, date and	place, and due	to the cause(s)	
	To the within 2 To the complet	M	29b. Signature and title of certifier.			29c. Lice	ense number		29d. Dat	e signed (Mont	h, Day, Year)	
)	- 10		1			D	19431		Janı	ary 2	1, 2008	
	3		30. Name and address of person who			*					20744	
			Frank M. Ryan, 31. Date filed (Month, Day, Year)		Livi	ngton	Road #1	103 Ft	Was	shingt	on, MD.	_
	Sta	1.00	JAN 2 2 200	32 Registrar's Signatur	Ana	AF D						
	Registra			ALL MERSONALES OF LAST	A STATE OF	1						

			1- State of Maryland / Dep Registrar Ce	artment of Health and Mertificate of Death		ene 2008	3 03057
	Dhyaja		Decedent's Name (First, Middle, Last)		2. Date of Death	1	3. Time of Death
0	Physicia /Medic		Francis John De Muth		Month January 1	Day Year L8, 2008	2:35 ^{p M}
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
			3113 Parker Avenue	Wheaton	2 D 1 - 5 Dial		toomery
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) Co	hplace (State or Foreign untry)
	100 -000		118–07–2623 87 Usual Residence of Decedent		May 13, 1	920	New York
	yland how at		10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
	e Mar la-fs	ctor	Maryland Montgomery W	heat.on			1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	untry?
	ath w	ral	3113 Parker Avenue	20902		USA	
036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto for 1 ☐ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	
21215-0036	hin 72 ho e. an "natur Medical I	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of workir DO NOT use retired)	ing 1	6b. Kind of Business/	Industry
21.	giene giene er tha	Com		Statistician		Federal Gove	mment
2	2 should be filed and Mental Hygi is marked other aumatic event, t	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name			LIMITELL
<u>S</u>	should b ind Menti marked	To	Frank Otto De Muth	Estella Couc	ghlin		
Maryland	2 sho and is ma			ng Address (Street and Number or Rura		-	Zip Code)
	1 and 2 Health Sem 27 i			bsquero Road, Spring Hi			
Itimore,	Page nent o ant; If		I LA Buriai 2 Li Cremation 3 Li Removal from State	matory or other place) ! _	ary 23	ilver Spring	
Balt	permit. Pag Department Important: I any Injury o		James & Owley 5	2. Name and Address of Facility rancis J. Collins Funer 00 University Blvd,. W.	ral Home In ., Silver S	Spring, MD 2	0901
ST	Physician	0	23a. Part1. Exter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition on the cause of		r respiratory arres		Approximate Interval Between Onset and Death
ar a	/Medical		disease or condition resulting in death) a. Organic Heart Disease Due to (or as a consequence of):				2 Years
	Examiner		Sequentially list conditions. b. Arteriosclerosis				2 Years
ER	Sit 3d	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				A SCHOOL OF
	ecute and trans	Examiner	that initiated events c. hypertension				2 Years
8760,	s be executed sician and burial-transit		Due to (or as a consequence of):				
	physic the p	dical	d				
.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	ivery Day Year
1	s that		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ras	w requires been signe should be	d by	Hyperlipoproteinemia		1 □ Yes	s 2 ² E No 3 □ Pr	obably 4 □Unknown
Vital Records,	has beer	Completed			24a. Was an autopsy	prior to d	topsy findings available completion of cause of
ā					performe 1∐ Yes 23	ed? death? ☑No 1☐Yes	2 □ No
X	siciar certii irecto	Be C	25. Was case referred to medical examiner? 1 Type 2 (\$1 No. Hospital: Type 1 Type 2 (\$1 No. Hospital: Type 2 (\$1 No. Hospital: Type 1 T	26. Place of Death			
Ö	Physer this eral di	2	27. Manner of Death 28a. Date of Injury 28b. Time o	1 3 BOA 4 Nursing Hor	ne 5 Residen 28d. Describe how	nce 6 Other (Spec	cify)
0	iding th. :: Afte e fune	tion	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	f 28c. Injury at 2 Work? M 1 ☐ Yes 2 ☐ No	.ou. Describe no.,	V Injury Goodned	
DIVISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Certification:	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, str building, etc. (Specify)		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
_	spital ours ours neral filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat	h occurred at the time, date and place a	and due to the car	uco(e) and manner as	atatad
	the Hos hin 24 h the Fur mpletely	Medical	one) 2 Meducal Examiner: On the basis of examination and/or in	ivestigation, in my opinion, death occurre	ed at the time, dat	te and place, and due	to the cause(s)
		2	29b. Signature and title of certifier	29c. License number D16495	290	d. Date signed (Month January 21	
	341	-				odridaty 21	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Joel Goozh, MD 10401 Old Georgetown Road,				
	Stat Registra		JAN 2 2 2008 32 egistrar's Signature	enti			

			For State	State of Ma	aryland				nd Me	ental Hyg	giene			
1		1	State Registrar 1. Decedent's Name (First, Middle, La	iet)		Cei	tificate of	Death			Reg. No	8	0 3 0 3. Time of E	58
7	Physici /Medi		Genesis	Dav	7is				1	2. Date of Dea Month Jan . 1	6,2008	Year	0023	Death M
	Examir		4a. Facility Name (If not institution, gi	· ·			4b. City, Town, o				4c. County of			
1	Euroval		Holy Cross Ho 5. Social Security Number 6.		e (In vrs. la	ast birthday)	Silve If Under 1 Year			8 Date of Birth	Mont		ery place (State or	Foreign
3 - 	Funeral Director			1□M 2 X F	, , , , , , ,	Yrs.	Months Days		Min.	Jan. 1	5 , 2008	Mar	yland	roreign
	and t		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						0d. Inside City	/ Limits
	Mary a-f sho filed a	tor	MD Montgo	mery	Мс	ontgo	mery Vi	llage					1 X ∑Yes	
	or 28s	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of Wh	nat Cour	ıtry?	
	eath w ns 23a must f	Funeral	19161 Stedwic	K Drive	Ever in LLS	2 13 1	208		n2 (Snaa	ify Vac or No.	USA 14. Race	- Amoric	ean Indian	
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2X N If Yes, Give Year or Dates:			Vas Decedent of H f Yes, specify Cub ☑ Yes 2☐ No	E⊥ Specify:	_ Sa	ican, etc.) lvado: malan	Black, Specify:	White,		
Maryland 21215-0036	thin 72 ho e. an "natui Medical	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed) College (1-4or 5	+)	(Give	ent's Usual Occup kind of work done OO NOT use retire	durina most o	of working	9	16b. Kind of Busi	iness/Ind	dustry	
2	led wi lygien her th it, the		0			1	none				none			
land	ould be fil Mental H arked ott atic ever	To Be	17. Father's Name (<i>First, Middle, Las</i> Mark Davis)						ia Cha	Maiden Surname, LVEZ)		
	and 2 should ealth and Men n 27 is marke ier traumatic		19a Informant's Name/Relationship Yesenia Chave		V		g Address (Street 51 Sted							
ore,	Pages 1 and the neut of He int: If Item		20a. Method of Disposition 1 A Burial ₄2 ☐ Cremation ∕3 ☐	Removal from State			sition (Name of natory or other place	ce)	Da		20c. Location - C			
altimore,	Part:		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	fy)	Ga		Heaven			2008	Silver			Md.
Ba Ba	permit. Departr Importa any inji		> Miles Dunl	dr		92	14m 14pd Apple 41 Colu	mbia	Blv	d.Sil	ver Spr	ICE ing	,P.A. ,Md20	910
	Physician		23a. Part1. Enter to disease, or con shock, or hear failure. List only Immediate Cause (Final					ng, such as ca	ardiac or	respiratory arr	est,		Approximate Interval Betwee Onset and De	een eath
	/Medical		disease or condition resulting in death)	a. Pulmon Due to (or as a			Jiasia						Smo.	
13 (5)	Examiner		Sequentially list conditions,	Oligoh			5							
	rted nsit	Examiner	Sequentially list conditions, if any, leading to inmodiate cause. Enter Underlying Cause (Disease or injury that initiated events	Urinar			rtion							
o,	an and rial-tra	Exa	resulting in death) Last	Due to (or as a										
8760	icate be executed physician and s the burial-transit	dical		d										
O. Box 6	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome particle 1 ☐ Live birth 1 ☐ Live birth 2 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3□	Ectopic pregnancy Other (specify)	,			23d. Date Monti		.,	ear
1	s that the ned by detac	by Ph	Part II. Other significant conditions	contributing to death bu	ıt not resul	ting in the un	derlying cause giv	en in Part I.		23e. Did tol	bacco use contrib	ute to tr	e cause of de	ath?
ords	requires that een signed by hould be deta								_	1 □ Y	es 2⊠No 3	☐ Prob	ably 4 □Un	ıknown
	The lay ate has page 2	Completed							_	24a. Was a autops perfori 1∐ Yes	sy pri- me <u>d?</u> de:	ere autop or to cor ath?]Yes	psy findings av npletion of cau 2□ No	/ailable use of
VITal		Be	25. Was case referred to medical examiner?	Hospital: X	-		Oth	3r:		Check onl on				
on or	ding Phys h. After this funeral di	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injur (Month, Day	у [2	R/Outpatient 28b. Time of Injury	28c. Injur Wor	4 LI NUISI	28		ence 6 Other ow injury occurred)	
DIVISION	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	2 Accident Investigatio 3 Suicide 6 Could not b 4 Homicide determined		ry - At hom :. (Specify)	ne, farm, stre		700 2 110		f. Location (St City or Town	reet and Number n, State)	or Rura	l Route Numbe	e <i>r</i> ,
	he Hospit n 24 hour ne Funera	Medical (29a. Certifier (Check only one) 1 Certifying Pl 2 Medical Example 1	ysician: To the best on the basis of and manner star	examination	rledge, death on and/or inv	occurred at the tirestigation, in my co	ne, date and p pinion, death	place, an occurred	nd due to the c d at the time, d	ause(s) and manr late and place, an	ner as st ad due to	ated. the cause(s)	
	To th	ž	29b. Signature and title of certifier	w N	10		29c. Licens	e number	~ //	2	9d. Date signed (Month, I	Day, Year)	×
	Dury's	-		W// / 11		20-1 77	115	SU)//		Jan 1	61	HUUX	>
			Paul E.Lev		15	00 Fc	rest G	en Rd	l.Si	lver	Spring,	Mď	20910	
	Sta Registra	te ar	31. Date filed (Month, Day, Year) JAN 22 20	08 32 egistra	ir's Signatu	ire dos	WE)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 08 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Sidney Euzent 2008 1105 P January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 01ney Montgomery Montgomery General Hospital 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2 □ F 88 Months Min. 219-07-3151 Yrs Director 11/27/1919 Baltimore, MD Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits Funeral Director MD Montgomery Gaithersburg 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or r must be r 20878 9701 Fields ROad #202 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or Items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1√ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: White WW II 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation traumatic event, the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesperson Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Euzent Ethel Macklin 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Abrams - Daughter 911 Lake Forest Drive Newport News, VA 23602 item 27 20b. Place of Disposition (Name of cemetery, crematory or other pla: Har Zion Tifereth Israel Cemetery 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pages 1 Department of H Important: If iter any Injury or oth 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 1/20/2008 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction Inc 1091 Rockville Pike Rockville MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sensis **Physician** /Medical Due to or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulbasse or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): attending physiclan for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1∐ Yes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TSAY Prince Philip Dr. Olney MD 20832 18101 31. Date filed (Month, Day, Year) JAN 22 32 Registrar's Signature State 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month January 14, 7:55 AM M Emilie W. Emshwiller 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 3738 Glen Eagles Drive Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) March 8, 1 Birthplace (State or Foreign
Country) Months Days Hours 1 □ M 2 □ F 248-30-4651 82 1925 South Carolina Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2√☐No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3738 Glen Eagles Drive 20906 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐ Yes 2/☐ No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tillman M. Williams Sallie Emilie Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy E. Adcock - Daughter Breeze Way Circle Olney, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State January 24 4 □ Donation 5 □ Other (Specify) Quantico National Cemetery Triangle, Virginia 2008 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd., W., Silver Spring, MD 20901 23a. Part1. Enth the disease, or complications that cau and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ears disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ELO GBNOSIS 1 ☐ Yes 2 ☐ No 3 Probably 4 NUnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒No autopsy performed? XXYes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1x Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

Registrar

State

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

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Examiner

Physician/Medical

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Completed

Be

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Certification:

Medical

29a, Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

2

Funeral

Director

show

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after

and Mental Hygiene. Is marked other than

Department of Health a Important: If item 27 Is any injury or other trains

Physician

/Medical

Examiner

physician and s the burial-transit

as attending | for use as

signed by the a

cate has been sig page 2 should b

certificate has

s after death.

I Director: After this certification by the funeral director, p

within 24 hours a completely filled

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2

that the death certificate be executed

P.O. Box 68760.

Division or Vital Records,

Pages 1 and 2 should be nent of Health and Mental

or other traumatic event,

Saltimore, Maryland 21215-0036

and manner stated.

CASDIANO

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEHRY

2008

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

1400 S soyet of AME WA 22202

Jan. 16 2008

08-00517 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jeffrey D. Eberhart State of Maryland / Department of Health and Mental Hygiene 2008 0306 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day January 18, 2008 0948 hrs **Medical Examiner EBERHART JEFFREY** DAVID 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Erederick** Rt. 75 @ Arlington Mill Road Libertytown 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreian Months Davs Hours Director 177-52-2206 Oct. 30, 1972 Country) PA 35 1 XM 2 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. Count 10c. City, Town or Location Yes 2 X No MD Frederick Iiamsville 23a or 28a-f show notified at once. hours after death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1905 Shelmar Drive 21754 United States Funeral 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 12 Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 X Married 1 X Yes Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White ş 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 lent of Health and Mental Hygiene.
ant: If item 27 is marked other than "I or other traumatic event, the Medical E Swimming Pool Baltimore, MD 21215-0036 Business Owner Company 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Duane Eberhart Paulette Flynn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1905 Shelmar Drive Ijamsville, MD 21754 Kathy A. Eberhart (Wife) 20c. Location - City or Town, State 20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery, crematory or other place Janos²⁴, 1 X Burial 2 Cremation 3 Removal from State St. Michaels' Cem. Loretto, PA Other Specify: Donation 5 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. /Medical Death a. Multiple Injuries Immediate Cause (Final disease *<u>xaminer</u>* or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed ending physician and use as the burial - trar Physician/Medical UNPENDED AMENDED Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? Yes 2 1 🗸 Yes 2 No 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death 25. Was case referred to medical Division of Vital Be examiner? Other: Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene this 1 ✓ Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Jan 18, 2008 After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Driver auto dump truck collision 0930 hrs 1 Natural 1 Yes 2 ✓ No Director: 5 Pending 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Rt. 75@ Arlington Mill Road , Libertytown , MD (Specify) Major Road / Highway To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1401

29b. Signature and title of certifier

Margarita Korell MD.

31. Date filed (Manth, DagYeg)

30. Name and address of person who completed cause of death (Item 23a)

2008

Assistant Medical Examiner

egistrar's Signatur

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

January 19, 2008

Certificate of Death

10:15 A M

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

vears

Year

1 ☐ Yes 2K No

North Carolina

4c. County of Death

Montgomery

United States

14. Race - American Indian,

Construction Company

Black, White, etc.

Specify: White

16b. Kind of Business/Industry

23d. Date of delivery

Day

Month

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 212 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🖾 Residence 6 Other (Specify) 28d. Describe how injury occurred 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) D26540 January 18, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carl I. Schoenberger, M.D., 16220 Frederick Road, #213, Gaithersburg, MD 20877

State Registrar

31. Date filed (Month, Day, Year 22 JAN



To the Hospital o within 24 hours aft To the Funeral Di

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Sharon Joyce Edwards	State of Maryland / Department of Health and Mental Hygiene

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,		1- For State Certificate of	Death	Reg.	ZUU No.	0 0300
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
ledical Examii		Sharon Joyce Edwards		January 14,	2008	2202 hrs
		,	c. City, Town, or Location of Deat	h	4c. County of Death	
		Sandstown Road	Goldsboro	(B) (B)	Caroline	(Ctata an
Funeral	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hr Months Days Hours Min		MM/DD/YYYY) 9. Birth Foreign	3
Director	L	222-76-6118 _{1 M 2} X _F 26 Yrs.		March	20 198100	intry) DE
ż.	H	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locatio	n		Т	10d. Inside City Limits
ом апу		DE Sussex Harbes				1 Yes 2 X No
daryland 28a-f show d at once,	흱		10f. Zip Code	100	. Citizen of What Coun	try?
ith the Maryland 23a or 28a-f sho notified at once.	Director	22719 Hurdle Ditch Road	19951		USA	
vith th			Decedent of Hispanic Origin? (§	Specify Yes or No-	14. Race - Americ	can Indian, Black,
eath w	Funeral	1 VNever Married 2 Married Armed Forces? If Ye	s, specify Cuban, Mexican, Puert		White, etc.	
fter d		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Yaar	Yes 2 X No specify:		Specify: W	hite
ours a atura	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Education (Specify only highest grade completed)	s Usual Occupation (Give kind of st of working life. DO NOT use re		6b. Kind of Business/In	ndustry
5 72 hc cal Ex	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	st of working life. DO NOT use re	urea)		
5-0036 Led within 7 Hygiene. other than the Medica	티	12 linew	orker	n	nanufactu	ring
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D 21215-0036 should be filed within 77 and Mental Hygiene. 7 is marked other than natic event, the Medical	Be C	Roy Wayne Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Pamela Address (Street and Number or		nt Edward	
O \(\frac{1}{2}\) \(\frac{1}{2}\) \(\frac{1}{2}\)	٩		9 Hurdle Dit		-	10051
ore, MEss I and 2 slot Health ar If item 27	ŀ	20a. Method of Disposition 20b. Place of Disposit	ion (Name of cemetery,	Date	20c. Location - City or	Town, State
ore History of History		1 Burial 2 Cremation 3 Removal from State crematory or oth		16/08	Chaster	Maryland
Baltimore, permit. Pages I an Department of Hec Important: If ite	- 1	4 Donation 5 Other Specify: Chesapeak 21. Signature of Funeral Service Licensee 22. N				
Baltimore, ME permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum		FI	ame and Address of Facility eegle and He	lfenbeir	Funeral	Home, PA
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	e mode of dying, such as cardiac	eensbore or respiratory arres	t, shock, or heart	pproximate Interval
/Medical	C 11	failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries				Between Onset and Death
aminer		or condition resulting in death) Due to (or as a consequence of):				
		Sequentially list conditions, b				
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=	xan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
cecuted		d				-
760, cate be ex physician he burial -	Medical	UNPENDED				
760, ficate be g physic sthe bur	/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fet	al death 3 Ectopic preg	nancy	23d. Date of delivery	y Day Year
lox 68 leath certificate attending for use as	ician/	past 12 months? 4 Pregnant at time of death 5 Oth	al death 3Ectopic preg er (Specify)	nanoy		,
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Recc The lav	Completed			perform 1 ✓ Yes 2		es 2 No
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hysic	2	1 Yes 2 No Inpatient 2 ER/Outpatient		•	Residence 6 🗸 Othe	r: Scene
Ing Pl		27. Manner of Death 28a. Date of Injury (Morth, Day Vear) 28b. Time of In Juny (Morth, Day Vear) 2139 hrs	njury 28c. Injury at Work?		ow injury occurred o struck a tree	
Sior Attend or death rector: by the	catio	2 Accident Investigation		204 Langtion (C)	reet and Number of Pr	ural Route Number, City
Division pital or Attendin ours after death. reral Director: A	ertification:	3 Suicide 6 Could not be determined (Specify) Local Street	it, factory, office building, etc.		ate) ad, Goldsboro, MD	arai Route Number, City
ospita hours unera ly fille	O	29a Certifier	red at the time, date and place, a	1		ted.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	(Check only one) Medical Examiner: On the basis of examination and/or investigation	on, in my opinion, death occurred	d at the time, date a	nd place, and due to the	ne cause(s)
To Vitl	Mec	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo	onth, Day, Year)
		() (and in land	O.C.M.E.		January 15, 200	8
		30. Name and address of person who completed cause of death (Item 23a)				
		Laron Locke MD Assistant Medical Examiner 111 Penn	Street, Baltimore, MD 2	1201		
	ate	31. Date filed (Month, Day, Year) 2008 32 Registrar's Signature	es .			
Regis	trar		4.7			
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			for Amend 10E Peir FH State Registrar AACO HEALIH DE	State of Marylan PT. 1/22/08 CMH		artment rtificate			nd Me		giene Rag. No.2	008	03	064				
	Physici	_	1. Decedent's Name (First, Middle, Last) James Thomas Ford)					_	Date of Dea Month anuary	Day	Year 2008	3. Time	of Death				
	/Medic Examir		4a. Facility Name (If not institution, give :	street and number)		4b. City, To	own, or l	ocation of				ounty of Deati						
		1.0	Anne Arundel Medic	cal Center			apo1					e Arun	del					
	Funeral Director		5. Social Security Number 6. Sec 579-16-9059	7. Age (In yrs. 87	last birthday) Yrs.	If Under 1 Months	Year Days	Hours	Min.	Date of Birtl (Month, Day 1/19/1	, Year) 920	Co	nplace (State untry) York	or Foreign				
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	cation							10d. Inside	City Limits				
	e-f sh	ctor	Maryland Prince Ge	orge's Bow	ie								1. ₹ Ye	es 2 🗆 No				
	3a or 28	i Dire	10e. Street and Number 14997 Health Cente	er Drive, Apt	231 . 203	10f. Zip C 2071					_	n of What Co ced Sta						
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show amy njury or other treumatic event, the Modical Examinar must be inclined at ance.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 TYes 2 □ No If Yes, Give Year or Dates: 1941		Was Decede If Yes, specifi 1 Yes 2	y Cuban	panic Orig , Mexican, Specify:	in? (Specif Puerto Ric	ly Yes or No- can, etc.)		. Race - Ame Black, White pecify: Wh						
21215-0036	rithin 72 hounder.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	16a. Deced (Give life.	dent's Usual kind of work DO NOT use	done du	tion Iring most	of working			of Business/						
22	lied v lygie ther t		17. Father's Name (First, Middle, Last)	1	Printe	er		18 Mother	's Name //	First, Middle,	Newsp							
au	lic eve	To Be	James Thomas Ford,	Jr.				Mae I		, , , , , , , , ,		,						
Maryland	2 should and he is main		19a. Informant's Name/Relationship (Ty									own, State, Z		9				
re, l	s 1 and f Health item 27 other t		Patricia F. Walsh, 20a. Method of Disposition	20b. F	15812 Place of Disponentery, crer	sition (Name	of		Dat			MD 2						
Baltimore,	Page ment o ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	las Cre	emator	y	01	/17/:	2008	Edgew	ater,	Maryla	and				
Balt	Deports Imports any nj		21. Signatur of Funeral Service License	00				of Facility	Georg	ge P. :	Kalas	Funer	al Hon	ne				
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Vital Records,		Completed										24b. Were au prior to death? 1 🗆 Yes	completion of	is available cause of				
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Division of \	ding Ph h. After th funeral	ition: To	1 Yes 2 No 27. Manner of Death t: Natural 5 Pending 2 Accident investigation	-lospital: 1 Inpatient 2 = 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury		c. Injury Work	4 □ Nur	28	d. Describe h		Other (Specoccurred	cify)					
Divis	Hospital or Attend 24 hours efter death Funerel Director: tely filled in by the	Certification:	a Could not be					28	28f. Location (Street and Number or Rural Route Number, City or Town, State)				umber,					
	To the Hospital or Attenwithin 24 hours efter deat To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Phy. (Check only one)	sician: To the best of my knot nar: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at vestigation, i	t the time	e, date and inion, deat	place, an	d due to the of at the time, of	cause(s) ar date and p	nd manner as lace, and due	stated. to the cause	ə(s)				
	To the within 2 To the complet	Me	29b. Signature and title of certifier	S. S. Marinor Stated.			License	0.7				signed (Mont						
5	x1_00	0	Barbara L	Bean Mi)	D	39	47/		l	leine	nary	162	008				
10	On.		30. Name and address of person who co Bear Barbara	1		Print) 202, M	100	lia	1 Par	hwi	my 1	Anna	polis	S -				
M. Parish	Sta Registi		31. Date filed (Month, Day, Year) JAN 1 7 20	32. Registrar's Signa	ature /													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 6:16 P M 17, 2008 William Deane Farren January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Fort Washington Hospital Fort Washington Birthplace (State or Foreign Country) Age (In yrs. last birthday Social Security Number Days Hours 1 ☑ M 2 ☐ F 82 1925 Washington D.C. 579-22-5473 Sept. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 21 No Maryland | Prince George's Accokeek 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 18108 Livingston Road 20607 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2K Married 1 ☐ Yes 2√ No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) U.S. Naval Elementary/Secondary (0-12) 12 College (1-4or 5+) Heavy Duty Equipment Inspector Department 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Virginia M. Jones William S. Farren 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gregory D. Farren/Son 1090 Carson Drive, Huntingtown, Maryland, 20639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 01/26/2008 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3035 Old Washington Road Huntt Funeral Home Waldorf, Maryland, 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Physician /Medical Examiner

Physician

/Medical

Directo

Funeral

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Be Completed

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner more.

burial-tran for use s been signe should be page 2 funeral within 24 hours after death To the Funeral Director: , completely filled in by the f

law requires that the death certificate be executed

or Attending Physician:

Division or Vital Records, P.O. Box 68760,

	Immediate Cause (Final disease or condition resulting in death)	aDue to (or as a consequ	Dendla	Infarc	tion		Criser and Dour				
ical Examiner	Sequentially list conditions, if any local to the state of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to or as a consequence. Due to (or as a consequence)									
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Completed by	DFM FNTA 24a. Was an autopsy performed? 1□ Yes 2 No 1 □ Yes										
Be	25. Was case referred to medical			26. Place of Dea	ath (Check only one)						
0	examiner? 1 ☐ Yes 2 📉 No	examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Special)									
ation: T	27. Manner of Dath 1 □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)									
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29c. License number

Surratts Red Clinton MD

29d. Date signed (Month, Day, Year)

-18-08

DHMH 17 Rev 1/2001

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R

Paterno

32. Redistrar's Signature

			1 _ State	State of Maryla		irtment of H tificate of L			giene Reg. No.	111117	3 03066
	ti =		Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ıth		3. Time of Death
F	Physicia /Medic	_	Stephen Vaugh	n Gudd				Month Jan	Day	2008	7:05 AM
	Examin		4a. Facility Name (If not institution, give stre		A 1	4b. City, Town, or			4c.	County of Dear	
		44	University of Maryle 5. Social Security Number 6. Sex	and Medical	rs. last birthday)	Balth If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	1		1timore
	uneral irector		1 💢 N		63 Yrs.	Months Days	Hours Min.	(Month, Day May 15	(, Year)	.4	thplace (State or Foreign ountry) Pennsylvania
pur	>		130-34-0403 Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Loc	cation					10d, Inside City Limits
Maryla	f sho	ō	Maryland Washing			gerstown					1 ☐ Yes 2 🎇 No
the l	r 28a- notif	irect	10e. Street and Number			10f. Zip Code			10g. Citiz	zen of What Co	
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er dea	tems ler m	nuel	11. Wartar Glates	Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 🛣 No	n U.S. 13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		 Race - Ame Black, White 	
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VIALIO Suld be file Mental Hy	c eve	o Be	unknown					known		,	
shoul and M	mar umati	٩	19a. Informant's Name/Relationship (Type	Print)	19b. Mailin	g Address (Street			er, City o	r Town, State,	Zip Code)
and 2	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Brenda L. Canfield		970	Security			erst	own Mar	yland 21742
gesta Tof He	If iten or oth		20a. Method of Disposition 1 ☐ Burial 2 【☐ Cremation 3 ☐ Ren	noval from State		natory or other plac	re) ¦	Date		ocation - City or	
Dartmit. Pages Department of	rtant: njury		4 □ Donation ¹ 5 □ Other (<i>Specify</i>) 21. Signature of Funeral Service Licensee			rg Cremat					Maryland
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OIVISION I or Attending after death.	ector: by the	ifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - building, etc. (Sp	At home, farm, str	eet, factory, office		28f. Location (Rural Route Number,
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1- >	, ,		1 Xhou	Boch	. MIS	17	433		Ja	n 21	2008
5H-	~		30. Name and address of person who com	0	0.	Print) Baltim	OF AAD	21201			
711	Sta	ate	31. Date filed (Month, Day, Year)	2 > 6 V e C i 32. Registrar's S		DALCING	U MID	400			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 008-03067 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 6.10 PM Jan 2008 /Medical 4a. Facility Name (If not institution, give street and number) County of Death Examiner Wia 101 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months 1□M 2XF Days Hours Min. 213-17-3529 5 1979 Jan. Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 XNo Director Columbia Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or 3 10799 Hickory Ridge Road #104 21044 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. <u>ک</u> 3 Widowed 4 Divorced white Completed event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n 27 is marked other than "ry traumatic event Elementary/Secondary (0-12) College (1-4or 5+) none 12 never worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Keegan Teresa Ann Griffin David Lawrence 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4919 Lerch Drive, Shady Side, MD Pages 1 ar ment of Heal. nt: If item 27 y or other tr Teresa K. Griffin, mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department o Important: If any Injury or once. Metropolitan Crematory 01-26-08 | Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 1. Signature of Juneral Service Lic. nsee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** owneredy disease or condition resulting in death) /Medical Due to (or as a conjequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Unknown Division or Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Disseminated Intravuscolor 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Δ
completely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10724 Little Deleva 31. Date filed (Month, Day, 32. Registrar's Signature Year) State JAN 2 2 2008 Registrar

			For State Registrar	State of M	laryland .		artment of F <i>rtificate of</i>			lental Hy	gien Rea. N	-2000	03068
			Decedent's Name (First, Mide	dle, Last)						2. Date of De	eath		3. Time of Death
	Physici		Louwenia Bott	Month Januar					ay Year 0, 2008	7:35am ^M			
	/Medical LOUWENIA BOTTET GTITITE 4a. Facility Name (If not institution, give street and number) 4b. City, Town,							or Location	n of Death		-	c. County of Death	
		y	Wilson Health				Gaither					ontgomery	
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days		er 24 Hrs. Min.	8. Date of Bir (Month, Da	ay, Yea <i>i</i>	r) 9. Birth	place (State or Foreign ntry)
	Director		306-40-0002 Usual Residence of Decedent		97					Jan. 3.	1, 1	910 Alab	ama
	yland now at		10a. State 10b. Count	ty	10c. City, T	own or Lo	cation						10d. Inside City Limits
	a-f st	ctor	Maryland Mont	gomery	Tako	ma Pa	rk						1 ☐ Yes 2X No
	iff the	Oire	10e. Street and Number				10f. Zip Code				10g. C	itizen of What Cou	ntry?
	ath w	Funeral Director	108 Grant Ave				20912					nited Sta	
	er de items ner m	nue	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	13. \	Vas Decedent of I f Yes, specify Cub	Hispanic C an, Mexic	Origin? (Spe an, Puerto	ecify Yes or No Rican, etc.)	D-	 14. Race - Americ Black, White, 	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Ma 3 ☑ Widowed 4 ☐ Divorce	If Yes, Give			∏Yes 2⊠ No	Specif	y:			Specify: Whi	te
215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	ted	,15. Decede	ent's Education	1	6a. Dece	lent's Usual Occup	pation			16b. I	Kind of Business/In	
215	thin 7 e. an "n Medi	aldu	(Specify only high Elementary/Secondary (0-12)	nest grade completed) College (1-4or	5+)	(Give life. L	kind of work done OO NOT use retire	during me d)	ost of work	ng	Dep	pt. Of Pu	blic
21	ed wi ygien ser th t, th	Completed		1	S	ocia	<u>l Worker</u>				1	elfare	
pue	be fill htal H d oth	Be	17. Father's Name (First, Middle	,						(First, Middle		,	
Maryland	ages 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygene. if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	2	William Turne: 19a. Informant's Name/Relation			10b Mailin	a Address /Street					illings or Town, State, Zij	- 0
Ma	id 2 s ith an 27 is i		Robert Griffi				Grant Av						Code)
ē,	s 1 ar f Hea ftem 3		20a. Method of Disposition	cii (Boil)	20b. Place		sition (Name of natory or other pla			Date		Location - City or To	own, State
8	Pages nent of I int: if ite		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (7		itan Cre		rv 1/	21/08	A1e	xandria.	Virginia
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service		,	22	Name and Addre	ess of Fac	ility De	Vol Fur			
8			(untio	E-Klay		Ġ.) East Do aithersb	eer r urg,	$\frac{\text{ark}}{\text{MD}}$ 20	877			
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that cause st only one cause on each	d the death. [line.	Do not ent	er the mode of dyi	ng, such a	as cardiac	or respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Adr	ilt	Ja	elu	re	40 /	hu	re	- 6	Onset and Death
1	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Adult failure to huve Due to (or as a consequence of the cons										
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	uted d ansit	min	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents	\		,							
o,	eath certificate be executed attending physician and for use as the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as	s a consequen	ce of):							
68760,	ate be nysicia he bu	edical		d									
	ertifice ing ph e as tl	Med	IF FEMALE:										
Вох	ath ce ttendi	Physician/M	23b. Was decedent pregnant	23c. If yes, outcome	2 Fetal de	ath 3	Ectopic pregnanc	:y				23d. Date of deliv Month	ery Day Year
0	the a	ysic	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	at time of deat	h 5□	Other (specify) _					Worth	Day Four
σ.	The law requires that the death certil ate has been signed by the attending page 2 should be detached for use a		Part II. Other significant condit	tions contributing to death	but not resultin	g in the ur	derlying cause giv	ven in Par	t I.	23e. Did	tobacco	use contribute to t	he cause of death?
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000	s been s s been s s should	Completed	Mypoth	graides	ne, *	y 22	eme	ره سه	/	24a. Was	an	24b. Were auto	psy findings available
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ita	nyslcian: The lis certificate hadirector, page	Be C	25. Was case referred to medic					26. Pla	ce of Death	1 Yes 1 (Check only		lo 1 □Yes	2 140
or V	Physician: r this certificaral director, I	To E	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpat	ient 2 □ ER	/Outpatien	t 3□ DOA Oth	ner: 4 🗹 i	Nursing Ho	me 5 Res	idence	6 □Other (Speci	(y)
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Sio	ttend feath. tor: /	cati	2 ☐ Accident invest 3 ☐ Suicide 6 ☐ Could	tigation	ium. Ashama			Yes 2		-0.1			
Division	or A after o	Certification:	4 ☐ Homicide deter	mined 28e. Place of in	tc. <i>(Specify)</i>	, rarm, str	eet, factory, office			28f. Location (City or To	Street a wn, Sta	and Number or Run te)	al Houte Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 Certify	Ing Physician: To the bes	of my knowle	dge, death	occurred at the ti	ime, date	and place,	and due to the	cause(s) and manner as s	tated.
	ne Ho n 24 h ne Fu oletely	Medical	(Check only 2 ☐ Medica one)	al Examiner: On the basis and manner s	of examination	and/or in	estigation, in my	opinion, d	eath occur	ed at the time	, date a	nd place, and due t	o the cause(s)
	Vithii Vithii Comp	ž	29b. Signature and title of certifi	ier		1	29c. Licens				29d. D	ate signed (Month,	Day, Year)
			1/ Kehre	Final	bar	an	1-10	41	15		VI	mung	20,2008
_	>		30. Name and address of perso	BIRICHO	death (Item 23	a (Type,	Print) 2	21	RU	SSCL	161	ANGUEN SI	20,2008
þ	Sta Registr	_	31. Date filed (Month, Day, Year JAN 22		rar's Signature	Con	de la						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 01/18/2008 6:00 PM CONSTANCE S. GORDON /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMERY BETHESDA SUBURBAN HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/08/1934 9. Birthplace (State or Foreign 6. Sex **Funeral** Min Months Days Hours 1 □ M 2X F NEW YORK 73 Director 084-26-2235 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show be notified at 1 Yes 2 No Director POTOMAC MARYLAND | MONTGOMERY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code P 12500 PARK POTOMAC AVENUE #608 20854 USA 'natural", or items 23a Examiner must Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Maryland 21215-0036 WHITE 1 ☐ Yes 2 ☐ No Specify: Specify: 9 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. Important: if Item 27 is marked other the any injury or other traumatic event, the 1 once. PUBLIC SCHOOLS 4 TEACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LILLIAN BOROW LEOPOLD GELB 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20854 LAWRENCE J. GORDON/HUSBAND 12500 PARK POTOMAC AVE, #608, POTOMAC, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State GARDEN OF REMEMBRANCE 01/21/2008 CLARKSBURG, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 21. Signature of Feneral Service Licensee

22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTI
1091 ROCKVILLE PIKE, ROCKVII

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20852 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 DAYS **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) Box 68760 physician certificate be Physician/Medical the use as 1 attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 K No Month 4☐Pregnant at time of death 5 ☐ Other (specify) Ö 9 ☐ Unknown signed by t d be detach ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ MULTIPLE MYELOMA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy page performed? certificate 2√ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 2 Inpatient □ this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: After or Attending (Month, Day Year) 1 X Natural 5 ☐ Pending investigation within 24 hours after dean...

To the Funeral Director: After the function of 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and tiple of contifier 29c. License number 29d. Date signed (Month, Day, Year) JANUARY 18, 2008 D0060117 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR EVA J. PARK, MD 8600 OLD GEORGETOWN RD, BETHESDA, MD 20814 31. Date filed (Month, Day, Year) egistrar's Signature State JAN 22 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 1- State Registrar Amend PII, perME, g876, 2/5/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Jan.18,2008 Goll Abraham 1930 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Bethesda Suburban Hospital Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 5. Social Security Number Months Days Hours 13K] M 2 □ F 123-01-0284 93 7/19/1914 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 □ No New York N.Y. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 10128 #4 East 88th Street 12. Was Decedent Ever in U.S. Armed Forces? 1. ☑Yes 2 ☐ No WWII If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Law Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown Goll Joseph 19a. Informant's Name/Relationship (Type. Print) Daughter19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Goll Lerner 5201 Brookeway Dr. Bethesda, Md. 20816 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 1/21/2008 Farmingdale, New York 4 □ Donation 5 □ Other (Specify) Beth Moses Cem 21. Signatural of Funeral Service Licenses PANTETED APPRENTATION FUNERAL SERVICE, P.A. lly 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Acute myocardial infarction days resulting in death) Due to (or as a consequence of): 10 years Arteriosclerotic heart disease CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Subdural hematoma non traumatic due to Coagulopathy due to anticoagulant therapy 24a. Was an autopsy perform

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

or be

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. once.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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with the Maryland

death v

Examiner Physician/Medical þ Completed Be Certification: To

Medical

Hospital or Attending Physician: The law requires that the death certificate be executed and attending physician for use as the buria After death. Director: 24 hours a within 2. To the I

Division or Vital Records, P.O. Box 68760.

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 🔀 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and of certifie

D13818

Jan. 28, 2008

V D

2

Gary/Fisher 31. Date filed (Month, Day, Year) State JAN 29

30. Name and address

5530 Wisconsin Ave. #730 Chevy Chase, Md 20815 32. Registrar's Signature

erson who completed cause of death (Item 23a) (Type, Print)

M.D

2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death $\overset{\text{Month}}{\mathsf{JAN}}$. **Physician** Kathleen Annette Garfield 2008 4:40 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Caroline Caroline Home for Hospice Denton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Nov. 27, 1 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Maryland 1 □ M 2 1 F 62 1945 Director 215-44-6481 Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at Federalsburg 1 ☐ Yes 2K No MD Caroline Director 10g. Citizen of What Country? 10e. Street and Number 21632 United States 3429 Houston Branch Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Black Specify: ģ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Medica1 Elementary/Secondary (0-12) College (1-4or 5+) Receptionist 12 of Health and Mental Hygier it item 27 is marked other the other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be iment of Health and Menta tant; If item 27 is marked jury or other traumatic ev Robert Joseph Adams Phyllis Turner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 308 Fountain Ave., Denton, MD 21629 Wanda C. Molock/Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important; If any Injury or Federal Hill Cem. 01/21/08 Federalsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 2415 disease or condition resulting in death) Due to (or as consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical as asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 ☐ Ectopic pregnancy for Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? δ 1 | Yes 2 No 3 | Probably 4 | Unknown Blood Dishers Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed certificate director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospica Way 2. No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

Maryland 21215-0036

Baltimore,

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Dondong Physicia

3304 Hazan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D, 0 29c. License number

H3347522

Drive Feder Churs MD

29d. Date signed (Month, Day, Year)

ì	Physician /Medica Examine
	Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

Regist

	For State Registrar		te of Deat		Reg.	No. 2008	03072			
Н	1. Decedent's Name (First, Middle, Last)	Day Year	3. Time of Death							
an cal	Jacey Christine Heue	3, 2008	4:37P ^M							
er	4a. Facility Name (If not institution, give street and number)		January 13, 2008 4b. City, Town, or Location of Death 4c. County of De							
	Anne Arundel Medical Center		apolis		I I	Anne Arun				
	5. Social Security Number 6. Sex 1 M 2 M F 7. Age (In yrs. la:	st birthday) If Unde Months		re Min	Date of Birth (Month, Day, Ye C. 10,	^{ar)} 1993 Mar	hplace (State or Foreign untry) yland			
	Usual Residence of Decedent 10a, State 10b, County 10c, City,	Town or Location					10d. Inside City Limits			
5		wnsville					1 □Yes 2 No			
ect	Maryland Anne Arundel Cro	Citizen of What Co	untry?							
흅			p Code 1032		Tog.		and y			
era	2114 Edwin Lane 11. Marital Status 12. Was Decedent Ever in U.S	USA 14. Race - Ame	rican Indian,							
표	Armed Forces? 1 Mover Married 2 Married 1 Yes 2 M No		edent of Hispanic ecify Cuban, Mex		an, etc.)	Black, White				
b D	The state of the	1 ☐ Yes	2 ∆ No Spec	cify:		Specify: Wh	ite			
Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usu	ual Occupation	most of working	16b	. Kind of Business/	Industry			
aldr.	Elementary/Secondary (0-12) College (1-4or 5+)		ork done during r use retired)	nost or working						
Co	0	Disabled				isabled				
Be	17. Father's Name (First, Middle, Last)			other's Name (Fi						
1º	Arthur Charles Heuer			ıra Chri						
	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Addres					zip Code)			
	Arthur C. Heuer/ Father 20a. Method of Disposition 20b. Pla	2114 Edwi		rownsvi		Location - City or	Town. State			
	1 M Bunal 2 □ Cremation 3 □ Removal from State									
	4 □ Donation 5 □ Other (Specify) Lake 21. Signature Funeral Service Licensee					las Funer				
	Sim P Kales . 1					ewater.Md				
	23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause of each line.						Approximate Interval Between			
	Immediate Cause (Final Respiratory-	Onset and Death								
	disease or condition resulting in death) RESPITATORY Due to (or as a consequence of the									
	Hypoxia									
iner	cause Enter Underlying	Due to (or as a consequence of):								
am	that initiated events c. Acute Respirat		SS							
Aedical Examiner	Due to (or as a consequence of the consequence of t	эпсе оі):								
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/Me	IF FEMALE: 23c. If yes, outcome pf pregnan	icv				23d. Date of de	livory			
cian	in the past 12 months?	death 3 ☐ Ectopic p				Month Month	Day Year			
Completed by Physician/N	1 ☐ Yes 2 📉 No 9 ☐ Unknown		, , , , ,							
Y P	Part II. Other significant conditions contributing to death but not result	ting in the underlying	cause given in Pa	art I.	23e. Did tobac	co use contribute to	the cause of death?			
pe pe	Congenital Cerebral Malformation	n, Hydroce	phalus,		1 ☐ Yes	2 X] No 3□ P	robably 4 □Unknown			
plet	Absent Eyes, Developmental Delay				24a. Was an	24b. Were a	utopsy findings available completion of cause of			
E O	autopsy prior to performed? death? 1 ☐ Yes 2 [X] No 1 ☐ Yes									
1 Yes 2 Mo 1 Yes 2 No No 1 Yes 2 No No No No No No No										
To		ER/Outpatient 3 □ D				e 6 □Other (Spe	ecify)			
ü.	27. Manner of Death 1	28b. Time of Injury M	28c. Injury at Work?		l. Describe how i	injury occurred				
cati	2 Accident investigation 3 Suicide 6 Could not be	1 ☐ Yes 2		Logation (Street	t and Number or P	um I Pouto Number				
rtifi	determined 20e. Flace of Illigary - At 11011	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and City or Town, State)								
il Ce	29a. Certifier 1 X Certiffing Physician: To the best of my know	se(s) and manner a	s stated.							
Medical Certification:	(Check only one) Medical Examiner: On the basis of examinati and manner stated.									
Me	29b. Signature and title of certifier	25	9c. License numb	oer	29d.	Date signed (Mon	th, Day, Year)			
1	M M Marilana	ſ	00013889		Ja	nuary 14	, 2008			
	30. Name and address of person who completed cause of death (item	23a) (Type, Print)								
	Robert G. Graw, M.D. 2772 Rutlan	d Road Day	vidsonvi	lle, Md.	21035					
ate rar	31. Date filed (Month, Day, Year) JAN 1 8 2008 32. Figistrar's Signature of Signa	t South								
4.1	JANES	S MANGALI								

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f sl must be notified

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseq c. Due to (or as a conseq d			-		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	al death 3 □Ectopic p			23d. Date of de Month	livery Day Year
Part II. Other significant conditions co	ontributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tobacc		o the cause of death? robably 4 □Unknown
				24a. Was an autopsy performed 1∐ Yes 2 ☑	prior to death?	utopsy findings available completion of cause of
25. Was case referred to medical			26. Place of De	eath (Check onl one		
examiner? 1 ☐ Yes 2 No	Hospital: 1 Impatient 2	IER/Outpatient 3 □ D	OA Other: 4 Nursing	Home 5□ Residence	e 6 □Other (Spe	ecifv)
27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how i		
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Special	ome, farm, street, facto	ry, office	28f. Location (Stree City or Town, S	t and Number or Fi tate)	lural Route Number,
	/sician: To the best of my kno niner: On the basis of examina and manner stated.					
29b. Signature and the of contifler	2 0	29	9c. License number		Date signed (Mon	

DHMH 17 Rev 1/2001

State Registrar

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within 24 hours a To the Funeral C

PODOX,730, SALISBURY UND 21802

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 2 3 2008

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31. Date filed (Month, Day,

CONSTAL HOSPICA

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 19^{Day} Month **Physician** 2008 Mary Rayne Hastings 8:45 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1 Meadow St. Unit 117 Gull Creek Berlin Worcester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex **Funeral** Hours Days 1 ☐ M 2 💢 F 216-56-0438 100 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examlner must be notified at 1 ☐ Yes 2 No Director Berlin Worcester MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 1 Meadow St. Unit 117 Gull Creek 21811 Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No à Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sand and Gravel Owner/Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jennie Powell Joseph Henry Esham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 Powelton Ave., Berlin, MD 21811 William T. Rayne/son permit. Pages 1 and Department of Health Important; if item 27 any Injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1/23/2008 Berlin, MD 21. Signature of Funera 7 rvice License 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 TYes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 XResidence 6 Other (Specify) 1 ☐ Yes 2 ☐ XNo 2 ER/Outpatient 3 DOA ၉ in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 29a. Certifier K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ça 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature tifle of certifier D-35764 1/19/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA 10 Bill Greer 12417 Ocean Gateway, Suite 5A, Ocean City, MD 21842 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 3 Registrar 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 8:35 PM HAGGENMILLER JANUARY 20 2008 OROTHY Adair /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ERIC 8. Date of Birth (Month, Day, Yea May 25, 1 9. Birthplace (State or Foreign Country) Washington, D.C 7. Age (In vrs. last birthday 5. Social Security Number 6 Sex **Funeral** Days Hours Min 1 □ M 2 🛛 F 1945 62 Director 213-46-5225 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Director Frederick MD Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21702 350 Montevue Lane Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 K No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No altimore, Maryland 21215-0036 Specify: Specify: White ģ 3 Widowed 4 Divorced 'natural", er than "natur, Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 is marked of traumatic ever Mary Elizabeth Greene William Henry Cusick, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9709 Dublin Road Walkersville, MD 21793 Janice Marie Smith/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Chesapeake Crematory | 01/22/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatele of Funeral Service Li 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part1. Enter the efsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death STAGE SMAN CELL LUNG CANCE Immediate Cause (Final MONTHS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 Mo 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached for 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed of þ 2 No 3 Probably 4 Unknown been si should I Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? Jas page 2 No 2 No 1 TYes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) His pick Hospital: 2 No 2 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury at Work? Certification: 1 Natural
2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 131761 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ENENTY ST. FREDERICK NO 21701 50/ W. MA Year) istrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar 29b. Signature and title of certifier

Anwarali T.

31. Date filed (Month, Day, Year)

29c. License number

M.D. 110 Hospital Drive, Prince Frederick, MD 20678

29d. Date signed (Month, Day, Year)

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D

32. Registra s Signature

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Allendin 30. Name and address of person who completed cause o death (Item 23a) (Type, Print)

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Munshi,

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2008 10:57 AM **JANUARY** 18, JOSEPH ALLEN HENDERSON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 5241 RED HILL DRIVE CHARLES INDIAN HEAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral X**□M 2□F Months Days 77 MAY 27, NEW JERSEY 1930 157-18-3308 Director Usual Residence of Decedent with the Maryland 10c City Town or Location 10d. Inside City Limits 10a. State 10b County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla pepartment of Health and Mental Hyglene. Internating them 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 28a-f show 1 ☐ Yes 2 No Director INDIAN HEAD MARYLAND CHARLES 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? UNITED STATES 20640 6750 HENSON ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 AYes 2 □ No If Yes, Give Year or Dates: 14. Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: ģ BLACK 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ORDNANCE MAN FEDERAL GOVERNMENT 12TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ELIZABETH MC CUFF HENDERSON JAMES HENDERSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2161 MERCHANTVILLE AVENUE, PENNSAUKEN, NJ 08110 PATRICIA BRANTLEY / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MARYLAND VEIERANS CEMETERY JAN. 28, 2008 CHELTENHAM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) Synature of Funeral Service Lie nsee THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 LYDIA C. THORNION JOHNSON MO0583 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lipe. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No page 2 should be detached the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2□ No 24a. Was an has autopsy performed 2 🗷 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify, 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 2 🗆 No 1 Tes death. 2 Accident Director: 6 ☐ Could not be 3 ☐ SuicIde 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital or Al 24 hours after of 4 Homicide 24 hours a 29a. Certifier 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. To the within 2 To the 29c. License number 29b. Signature and title of certifier 00008370 La BUCK and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

2

31. Date filed (Month, Day, Year)

agrange Ave. P.D. Box 1317 Laplata, md 201046

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Maria Luisa Hernandez-Perez 6:30 P /Medical January, 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda er 1 Year | If Under 24 Hrs. Montgomery

9. Birthplace (State or Foreign Country) If Under 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6 Sex Days Hours 1 □ M 2 □ F Yrs. 216-58-9420 Jan. 31, 1921 Cuba Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 □XNo Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1400 Fenwick Lane, #505 20910 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1X Yes 2□ No Cuban White þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pablo M. Hernandez Oroczo Victoriana Garcia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hilario Carvajal/Nephew 4605 Calvert Street, #203, College Park, MD 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State tx☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. 22, Maryland National 4 ☐ Donation 5 ☐ Other (Specify) 2008 Laurel, Maryland Memorial Fark Address of Facility

Physician /Medical

Funeral

Director

e filed within 72 hours after death with the Maryland al Hygiene. other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

other traumatic event,

Pages 1 and 2 should be 1 is marked o

permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tra

Immediate Cause (Final disease or condition resulting in death) Examiner Examiner

IF FEMALE:

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and sician and burial-tran attending physician for use as the buria Physician/Medical MeDICAL Completed Be Certification: To 500

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknow

in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

5 Pending investigation

6 Could not be determined

2 2 2008

1 ☐ Yes 2 X No

27. Manger of Death

1 Natural

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN

3 ☐ Suicide

29a. Certifier

21. Signature of Funeral Service Licensee

como

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

5 ☐ Other (specify) 9□Unknown

28b. Time of

Injury

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Carely

Due to (or as a consequence of)

Due to (or as a consequence of)

Due to (or as a consequence of)

3 ☐ Ectopic pregnancy

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ₺₺0 24a. Was an autopsy

Inc. Spring, MD 20901

Approximate Interval Between Onset and Death

Year

26. Place of Death (Check only one

performe

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

🛍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

Francis J. Collins Funeral Home 500 University Blvd, W., Silver

San, MA

Hospital: 1 Impatient

28a. Date of Injury (Month, Day Year)

2005 2124

1119108

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Truong Bao, MD 9715 Medical Center Drive, #201, Rockville, MD 20850

State Registrar

rlea Medical

32 Registrar's Signature



State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) JAN 22

2008

EISEHATSION

MEHART

s of person who completed cause of death (Item 23a) (Type, Print)

0006447

Hospital Drive Cheverly MD 20785

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician Wavne Hart 2008 /Medical 4b. City, Town, or Location of Death Salisbury, MD 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** regiona edical (tenti DICOMICO ninsula If Under 1 Year | If Under 24 Hrs. 6. Sex Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Days Hours Director 220-32-1762 7-23-1936 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be matrified at once. 10c. City, Town or Location 10a State 10b. County 10d, Inside City Limits 1 ☐ Yes 2 No Director Salisbury MD Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4982 Nutters Cross Road 21804 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1♥ Yes 2□ No 1954— If Yes, Give Year or Dates: 1956 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race · American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Marýland 21215-0036 1 ☐ Yes 2 No ģ Specify: 3 ☑ Widowed 4 ☐ Divorced White 1956 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Bookkeeper Electric Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Garland ပ Ε. Hart Nellie Budd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ear1 Hart 31175 Old Fruitland Road, Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 NOther (Specify)Entombment | Springhill Memory Gd 1-23-2008 Hebron, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bounds Funeral Home 705 E. Main_Street, Salisbury, Maryland 21804 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MASNIE 6 BSTRUCTURE PULMONAM YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Uniknown Completed certificate has b irector, page 2 sl 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performe 2 1No 1 ☐ Yes 2 ☐ No 1∐ Yes director. Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 □ ER/Outpatient 3 □ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: 24 hours a npletely within 2. State

Registrar

29b. Signature and title of certifier

KeNE

31. Date filed (Month Qa)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

CSMAIAIS

SALISH

400 E. Shore

32. registrar's Signature

29d. Date signed (Month, Day, Year)

			For State Registrar	State of Maryla	nd / Depa <i>Ce</i>	artment rtificate	of He	alth and eath	d Men		giene Reg. No.	000	03081
,	Physicia	an	1. Decedent's Name (First, Middle, Las Harry Franci	is Holecheck	3					ate of Dea Month N	ath Day	2008	3. Time of Death 9:30 A M
	/Medio Examin		4a. Facility Name (If not institution, give	street and number)			Town, or Lo	ocation of De			4c.	County of Death	
	Funeral Director		5. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 7. Social Security Number 8. Social Security	ex 7. Age (In yrs	last birthday, Yrs.	If Under Months		If Under 24 H Hours M	Irs. 8. E	pate of Birth Month, Day 1 L y L (year) 0,19	9. Birthi Coul Mar	place (State or Foreign ntry) y Land
	yland		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity. Town or L	ocation							10d. Inside City Limits
	death with the Maryland ma 23a or 28a-f show rmust be notified at	ector	MD Dorches	ster		10f. Zip		ur1oc	k		10g. Cit	izen of What Cou	1 ☐ Yes 2 🙀 No ntry?
	3a or 3	Ö	6631 Palmer M:	ill Road		101. Zip		1643			-	ited St	
36	J within 72 hours after death with the Marylar jiene. Than "naturel," or Itama 23a or 28a-f show the Madical Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ X Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 146	J.S. 13.	Was Deceded of Yes, special Yes 2	-	panic Origin? Mexican, Pu Specify:	(Specify Jerto Rica	Yes or No- n, etc.)	•	14. Race - Ameri Black, White, Specify: Wh	etc.
5-0036	72 hou nature lical E		15. Decedent's Ec	ducation	16a Dece	dent's Usua kind of wor	I Occupation	on ring most of	working		16b. K	ind of Business/Ir	ndustry
	within 72 ene. than "nai	Completed	Elementary/Secondary (0-12) 11 (Grad.)	College (1-4or 5+)	4		-	0pera			E . :	I. DuPo	ont
Maryland 2	uld be filed fental Hygie rked other lic event, L	To Be Co	17. Father's Name (First, Middle, Last) Louis Charles					8. Mother's P Marie	,			Sumame)	
Zar Z	12 should and h		19a. Informant's Name/Relationship									or Town, State, Zi ck, MD	
	s 1 and f Heaith itam 27 other to		Mary E. Holeche	20b.	Place of Disp cemetery, cre				Date	, mu		ocation - City or T	
altimore,	0 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	y) Ea	stern	Shore	Vete	ran 01				lock, Ma	
Ball	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Licer Multure 7	Gelson	2	16 N.	Main	St.,	Fede	ra1sb	ourg	ral Home , MD 216	P.A. 32
	Physician physician executed white purial-transit physician end purial-transit physician executed with the principle of the principle of the physician end o	Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse	quence of):	Jacke L	en j	gol for	Int la	- By	, ~	Person	Interval Between Onset and Death
Box 68/60	ath certific attending p for use as	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of preg 1 \(\subseteq \text{Live birth} \) 2 \(\subseteq \text{Fe} \) 4 \(\subseteq \text{Pregnant at time of} \)	tal déath 3	□Ectopic pr						23d. Date of deliv	very Day Year
э. О	res that the de signed by the a l be detached		9 ☐ Unknown Part II. Other significant conditions of	9□ Unknown contributing to death but not re	sulting in the	underlying ca	ause given	in Part I.		23e. Did t	obacco	use contribute to	the cause of death?
ords	w requires been sign should be	ted by							_	1 🕏	es 2	□No 3□Pro	obabły 4 □Unknown
Vital Records,	The lay ate has page 2	Completed								24a. Was autor perfo 1 ☐ Yes		death?	opsy findings available ompletion of cause of 2 \(\sum \text{No} \)
	ysician: The is certificate his director, page	To Be	25. Was case reterred to medical examiner? 1 ☐ Yes 2 ☐ Mo	Hospital: 1 ☐ Inpatient 2	FR/Outpatie	ent 3 DO	Other	26. Place of				6 ☐Other (Spec	ufy)
Division of	ding Ph After th funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury		28c. Injury a Work?					iry occurred	
DIVIS	To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: After this certific; completely fifled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined			treet, factory	y, office		28f.	Location (City or To			ral Route Number,
	Hospit 24 hour Funerately fille	edicai (29a. Certifier 1 Certifying Pt (Check only 2 Medical Example)	mysician: To the best of my kiminar: On the basis of examiliand prafiner stated.	nowledge, dea nation and/or i	ith occurred nvestigation	at the time , in my opin	, date and p nion, death o	lace, and occurred a	due to the	cause(s date an	s) and manner as ad place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certification	nt			c. License				29d. Da	ate signed (Month	n. Day, Year)
				for	as) =		12	979	1		/	19/2	
			30. Name and address of person who William Rob	ins, M.D.	200 C:		Ave.	, Sal	lisb	ury,	MD	21804	
	Sta Registi		31. Date filed (Month, Bank) and 3	2008 32. Resistrar's Sig	nature	Sec.	1						

18 M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 709 M KENNETH R. JENKINS 2008 Januar /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salishury If Under 1 Year of Peninsula WICOMICU 8. Date of Birth (Month, Day, Year) 6-16-1939 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 1**X** M 2□ F DELAWARE 68 221-22-5180 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show 1X Yes 2 □ No Examiner must be notified Director DELAWARE SUSSEX SELBYVILLE 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code ō 225 CYPRESS ROAD 19975 US items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Americen Indian 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1966 1 ☐ Never Married 2 X Married 0 1 ☐ Yes 2 No Specify. WHITE Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If Item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER TRUCKING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EDGAR ROBERT JENKINS BESSIE ROGERS ٩ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA A. JENKINS/ WIFE 225 CYPRESS RD, SELBYVILLE, DE. 19975 20b. Place of Disposition (Name of DACSBORO REDMENS MEMORIAL CEMETERY 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State injury or 5 ner (Specify) 1-24-08 DAGSBORO, DELAWARE 4 Donation 22. Name and Address of Facility MELSON FUNERAL SERVICES, LTD. 43 THATCHER ST, FRANKFORD, DELAWARE. fignature Fune Se 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Shock Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Difficile Colitus lostridium Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed and -trar Due to (or as a consequence of): use as the burialattending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 | Fetal death 3☐Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Liver Failure, Coaquiapathy 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an cance suphageal , page 2 has autopsy After this certificate 1∏ Yes 2 💢 No Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 🛛 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending (Month, Day Year) Injury 1 Natural 5 Pending To the nospinal within 24 hours after death. To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Division or Vital Records. the Hospital

Box 68760.

P.O.

5180

72

altimore, Maryland 21215-0036

BA2

State Registrar

Medical

David Walker 31. Date filed (Month, Day, Year) JAN 2 3 2008

29b. Signature and title of certifier

(Check only one)

30. Name and ad 👉 s of person who completed cause of death (Item 23a) (Type, Print) 560 Riverside Dr.

32. Registrar's Signature

Salisbury, md. 2180

29c. License numbe

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] § Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** lanuary 5:15 A George Evans Johnson 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline 27158 Hobbs Road Denton If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 □ F 212-16-7971 87 Sept 16, Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 ☐ No Director Maryland Caroline Denton 10g, Citizen of What Country? 10e, Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be n any injury or other traumatic event, the Medical Examiner must be n any injury or other traumatic event, the Medical Examiner must be n any injury or other traumatic event, the Medical Examiner must be n any injury or other traumatic event, the Medical Examiner must be n any injury or other traumatic event. 21629 United States of America 27158 Hobbs Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1943-1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: 9 1945 Caucasian 3 ☐ Widowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Agriculture/ Elementary/Secondary (0-12) College (1-4or 5+) Maintenance/Farmer County Roads 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Franklin Lillian Hamilton ပ Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21629 19a. Informant's Name/Relationship (Type. Print) 5250 Clark Canning House Road, Federalsburg, Maryland pate | 20c. Location - City or Town, State Daughter Wanda Cooper 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 → Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/30/2008 Concord, Maryland Concord Cemetery 22. Name and Address of Facility
Moore Funeral Home, P.A.
12 South Second Street, Denton, Maryland 21. Signature of Funeral Service Licensee 23a. Part1. Enter the diseast or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician months /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burial-trai Due to (or as a consequence of). IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 🗌 Yes 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 No cate has page 2 s 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Mann eath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Laccident ∈ □ Could not be 3 ☐ Suicide 4 Thomicide

Division or Vital Records, P.O. Box 68760,

4 Homicide	determined	28e. Place of injury - At home, farm, stree building, etc. (Specify)	t, factory, office	City or Town, Sta	and Number of Hural Houte Number, ate)
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a. Certifier (Check only one)		cian: To the best of my knowledge, death of er: On the basis of examination and/or inve- and manner stated.			
b. Signature and	tille of certifier		29c. License number	29d. D	Date signed (Month, Day, Year)
1	12/1/2	cer M.D.	D6306	3 _{Jai}	nuary 28, 2008
. Name and addre	ess of person who cor	npleted cause of death (Item 23a) (Type, Pr	int)		
Stephen	Rualo, M. I)., 609 Daffin Lane,	Denton, Marylan	ed 21629	

State Registrar

Medical

29a. Certifier

(Check only one) 29b. Signature and

30. Name and addr

31. Date filed (Month, Day, Year) JAN 2 9 2008

32. Regenrar's Signature

			1 - For State Registrar		aryland / De <i>C</i>	partmer ertifica	nt of H	ealth a Death	and M	R	eg. No.	08	03084
	Physici		Decedent's Name (First, Middle, La Albert Allen							Jan. 18		8 Year	3. Time of Death 10:15a _M
	/Medic Examin		4a. Fecility Name (If not institution, given Julia Manor H		nter			Location o				ty of Death hingt	ton
	Funeral Director		217 20 0111	Sex 7. Age	76 Yrs	Months	r 1 Year Days	If Under a	Min.	8. Date of Birth (Month, Day 8-9-15	31	9. Birth Cou MI	place (State or Foreign intry)
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Washin	gton	10c. City, Town or Hagers								10d. Inside City Limits 1 Yes 2 No
	with the	i Direc	10e. Street and Number 559 Salem Av	e .			p Code 2174	0		1	0g. Citizen o		intry?
960	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Cepartment of Health and Mental Hygiene. Cepartment of Health and Mental Hygiene. Interportant: If item 27 is marked other than "natural", or Itams 23a or 28a-f show important: If item 27 is marked other than "natural", or Itams and 12a hours in the modified at other.	I by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	Ever in U.S. 1	3. Was Dece If Yes, spe		spanic Origin, Mexican	gin? (Spe , Puerto I	city Yes or No- Rican, etc.)	14. Ra	ace - Ameri lack, White white	etc.
21215-0036	d within 72 ho piene. r than "natu the Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 8th grade	ducation a de completed) College (1-4or 5	(G	cedent's Usu ive kind of wo e. DO NOT u	ork done d use retired	turing most ()	t of workii	ng	16b. Kind of stone		
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	1 and 2 sho Health and tem 27 Is ma		19a. Informant's Name/Relationship (Cindy Schildt	Type, Print[daug] knecht	128	301 L	ittl	e El	liot	/Route Number	Hage	rstov	vn, MD
Baltimore,	permit. Pages 1 Department of He Important: If iter any injury or oth		20a. Method of Disposition OBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	5)	20b. Place of Discometery, of St. Pau	in Cer	other plac nete	- 1	200	22, (20c. Location Clear	Spri	ing, MD
Ball	Departing Important any in		23a. Particular the disease, or com		the death Deach	Dona.	ld E	dwin	Tho	mpson ar Spri	Fune:	ral H	Home, Inc
	Fnysician /Medical		stock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a OST	a consequence of):	anter the mo	ae or ayırı	y, such as	cardiac	i respiratory arr	est,		Interval Between Onset and Death
8760,	Examiner	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to or as	a consequence of):	AA	en	0)1	Sai	\$e			Syloy
O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal death	3 □Ectopic p 5 □ Other (s						Date of delivery	very Day Year
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Vital	Physiclan: The this certificate hiral director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpa	tient 3 D	OA Oth	or:		n <i>(Check only or</i> me 5 ☐ Resid		Other (Spec	afu)
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Division	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 8	Certification:	3 Suicide 6 Could not be determined		ury - At home, farm, c. (Specify)	street, facto	ry, office			28f. Location (S City or Tow	treet and Nur n, State)	mber or Ru	ral Route Number,
	• Hosp 24 hou • Funer letely fill	edical		n ysician: To the best miner: On the basis o and manner st	examination and/o								
	within To th compl	Me	29b. Signature and title of certifier			29	c. Licens	and the same of th	2 -		29d. Date sign	ned (Month	n, Day, Year)
5	AS.		30. Name and address of person who	completed cause of a	eath (Item 22a) (T	ne Print	1-7	(2)	163		1/18	18	
			Dr. Farid Mur	shed 112	6 Opal		Нас	gerst	own	, MD 2	1740		
	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 4 20	08 32 legistr	ar's Signature	houle	•						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 19, 10:40A M Melvin Knox, Jr. 2008 January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Glenarden Prince George's 8621 Fulton Avenue If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Director 69 May 20, 1938 Texas 456-60-5797 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10h. County 1 Yes 2 No Director Prince George's Glenarden MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 20706 USA 8621 Fulton Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 XNo 1 ☐ Yes 2 X No Specify à 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruthie Mae Wilson Melvin Knox, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8621 Fulton Ave Glenarden, MD 20706 Joyce I. Knox/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Chesapeake Crematory: 01/23/08 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final elow CONGR Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tra Due to (or as a consequence of): physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) ed by the a Tyes 2 No 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1□ Yes 2X No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be ၉ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 X Natural 2 ☐ Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No spltal or Attendi nours after death. neral Director: A 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Md 20882 January 22, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 Irving Street NW #218S Washington, D.C. 20010 Daya S. Sharma, M.D.

10 EG

Baltimore, Maryland 21215-0036

death certificate be executed

P.O. Box 68760.

Division or Vital Records,

Physician:

Hospital

State Registrar

31. Date filed (Month, Day, Year) **JAN 23** 2008



Division	To the Hospital or Attending F	within 24 hours after death. To the Funeral Director: After	completely filled in by the funera	Medical Certification:
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any Injury or other traumatic event, the Mudical Examinar must be notified at ones. To Be Completed by Funeral Director	10e. Street and Number 1160		лшѕ,303	10f. Zip C	ode 1 01-	33908		10g. Citizen of USA	f What Coun USA	try?	
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To	Paul P. Lopata					ma Put					
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State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 03087 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 7:24 P.M. Franklin Scott LEITER Jr. January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct. 22,1919 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 🔀 M 2 🗆 F 88 Oct. 219-01-9270 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int. If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21740 10921 Knotty Pine Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 TxYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No 3altimore, Maryland 21215-0036 Specify: white þ WW II 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) transmission center owner 12 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna McCardell Franklin S. Leiter ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains Virginia Ruth Leiter - wife 10921 Knotty Pine Drive, Hagerstown, Md. 21740 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 157 Burial 2 ☐ Cremation 3 □Removal from State 1/28/08 Hagerstown, Maryland 4 □ Donation 5 □ Other (Specify) Rose Hill Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on good line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (of as a consequence of); Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as/a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 NO Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 7 10 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Anatural in 24 hours are, the Funeral Director: Afternately filled in by the funeral properties of the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STANT SVICE OH-1211 Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

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31. Date filed (Month, Day, Year) State JAN 25 Registrar

30. Name and

29b. Signature and title of certifier

MAYUR

32. Registrar's Signature

ress of person who completed cause of death (Item 23a) (Type, Print)

NARAYAN

2008



29c. License number

8239

SOUTH GREENE STREET BALTIMORE, MD

29d. Date signed (Month, Day, Year)

as

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 3. Time of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day **Physician** 5:20 A M JAN. 19 2008 JAMES EDMUND GOLT LEAGER, SR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner ST. MARY'S CHARLOTTE HALL CHARLOTTE HALL VETERAN HOME If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Days Months Hours 1 X M 2 □ F MARYLAND AUG. 24. 1913 212-16-1645 94 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10b. County 10a, State 1 ☐ Yes 2X No Director CHARLOTTE HALL ST. MARY'S MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygene.

In mortant: If idem 27 is marked other than "natural" or items 23a or any injury or other traumatic event, the Medical Examiner must be a mark injury or other traumatic event, the Medical Examiner must be a USA 20622 29449 CHARLOTTE HALL ROAD Funeral 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Poices: 1 **X**Yes 2 □ No If Yes, Give Year or Dates: **1941--1945** 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No altimore, Maryland 21215-0036 Specify: WHITE þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HARDWARE SALES CLERK 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last, Be AVIS GOLT W. BURGESS LEAGER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8976 HIGH BANKS DRIVE, EASTON, MD 21601 JOHN LEAGER/ SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1-24-2008 CENTREVILLE, MD CHESTERFIELD CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): MURS **Examiner** ONAN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectonic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No detached 9 Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? (es 2 No death? 2□ No 1□ Yes **Division or Vital** 26. Place of Death (Check only one) director. 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 0 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d, Date signed (Month, Day, Year) 20c License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AND, MO, 100 HOSPITAL ROAD, PRINCE FREDERICK, MD 20678 MIMS 32. Ragistrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 2 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month 130A **Physician** TOLA HOWARD WILMER LEE, JR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LOCH RAVEN CENTER BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | JULY 12, 1929 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**▼**M 2□F MARYLAND Director 218-24-2993 78 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f shov is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. It was 23 or 28s-f should be 72 is marked other than "natural", or Itema 23s or 28s-f show other traumatic swant, Ita Medical Examinational Demolities at 1♥ Yes 2 No Director BALTIMORE MD 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21212 UNITED STATES 744 EAST COLD SPRING LANE Completed by Funeral 12. Was Decedent Ever in U.S. Amed Forces?

1 Mayes 2 No 1951
If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE LABORER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland Be VICTORIA MARIE BOND LEE HOWARD WILMER LEE, SR. ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 744 EAST COLD SPRING LANE, BALTIMORE, MD 21212 KATHERINE I. COOK/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ō 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) permit. Page Department of Important: If any Injury or once. = 5 MD VEIERANS CEMEIERY 01/23/2008 CHELTENHAM, MD 21. Signatury of Funeral Service Licenses THORNTON FUNERAL HOME, P.A. TYDÍA C. THORNTON JOHNSON MO0583 3439 LIVINGSION ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine inding physicien and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year ö 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Be Completed by cete has been signi, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? certificate 2/2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification; To 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA his 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 X Natural 5 Pending s effer dec. 1 ☐ Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Funstal Dir.
To the Funstal Dir. 29a. Certifier 🔀 Contifying Physician: To the best of my knowledge, death conured at the time, date and place, and due to the basic(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause ath (It m 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 12, January 2008 2:20 Lewis Arthur D /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring
If Under 1 Year If Under 24 Hrs. Renaissance Gardens Montgomery Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Min 1 X M 2 □ F Director 465-10-8128 89 Sept. 13, 1918 Texas Usual Residence of Decedent 10d. Inside City Limits be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☑ Yes 2 ☐ No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20904 3144 Gracefield Road #317 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates: 944-1945 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White "natural", 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) af Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Transportation 4 Executive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Mental h Carl Lewis Ida Maxie Curtis ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other trai Gregory S. Lewis / Son 6512 Western Avenue, Chevy Chase, Maryland 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Fort Lincoln Crematory 1/21/2008 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Simple Tribute Funeral and Cremation Center 1040 Rockville Pike; Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failude. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Days **Physician** Pneumonia /Medical Due to (or as a consequence of): Examiner Dysphagia Months Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed Laryngeal Cancer Years that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Por Month Day in the past 12 months? 5 ☐ Other (specify) 4□Pregnant at time of death signed by the aid to be detached for 1 Yes 2 No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Tes 2 No 3 Probably 4x Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No certificate has page 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After Hospital or Attending 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No death. ours after death.
neral Director: /
filled in by the fi 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide vithin 24 hours 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) nd title of certifie 29c. License number 29b. Signature D24035 1/18/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 E.S. Machado, M.D. 3110 Gracefield Road, Silver Spring, MD 20904 31. Date filed (Month, Day, Year) Registrar's Signature State JAN 22 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. item 4a-c per doc 878 4-9-08 wt. 1 - For State Registrar Reg. No. 2008 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1^{Day}, 20^V08 JAN . 3:00 А м **Physician** Ruth E. Lankford /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Mallard Bay Nursing Home Cambridge Dorchester Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
Sept. 26,1929 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Min 78 1 □ M 2 1 1 X Sept. Maryland 213-24-0222 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location show 10a. State 10b. County 1 ☐ Yes 2 X No Federalsburg Caroline Examiner must be notified Director MD 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21632 United States 3772 Houston Branch Road items 23a Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3√Widowed 4 Divorced 'natural", Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) injury or other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) is marked other than Licensed Pratical Nurse Nursing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Della Wroten Robert Lee Elzev 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2.
Department of Health ar.
Important: If item 27 is n. 3772 Houston Branch Rd., Federalsburg, MD 21632 Michael Lankford/Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hill Crest Cemetery | 01/22/08 | Federalsburg, MD ^{22. Name and Address of Facility}Framptom Funeral Home 216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licensee CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 I Inknown 9 Unknown certificate has been signed by rector, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ģ 1 Tyes 2 No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Hospital: 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) within 2, To the F and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar BYRN ST. CAMBRIDGE, MD-21613

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1 - State Registrar 03093 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Ralph Albert Mauk January 16, P^{M} 2008 1:44 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 XM 2 □ F 214-46-0492 63 July 10, 1944 Maryland Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 □Yes 2 No Maryland Anne Arundel Davidsonville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3316 Beall Drive 21035 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 **N**O altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: White Completed by 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. Item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Driver State of Maryland 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert L. Mauk, Sr. Lena Caldwell ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun Carolyn Paddy/sister 3316 Beall Drive Davidsonville, Maryland 21035 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore Crematory 1/19/2008 |Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funerny's void 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Intra **Physician** abolo mi nal disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner anastomotic Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Physician: The law requires that the death certificate be executed oloncanur with Obstruction burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician the as attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No certificate ! funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔣 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: the 6 Could not be a 24 hours after des ae Funeral Directo pletely filled in by th 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely within 2. To the I and manner stated. 29b. Signature and title of crifier 29d. Date signed (Month, Day, Year) 29c. License number ပ္ 46052 30. Name and address of person the completed cause of death (Item 23a) (Type, Print) Sound Blub, TWD 2001 Medical Penhway strar's Signature 31. Date filed (Month, Day, Year) State **JAN 18** 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () () 8 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 3:48 AM Aline E. Macknovitz 2003 Tanuary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Baltimore Washington Medical Center Glen Burnie 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6, Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗶 F 85 217-14-3694 **Director** Maryland 24,1922 Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Severna Park MD 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? If than "natural", or Items 23a or the Medical Examiner must be USA 21146 709 Oak Grove Circle Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify: White Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Engineering Firm Bookkeeper 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any lighty or other traumatic event once. Be Anna A. Szymanski Kostanty Dawidowicz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 709 Oak Grove Circle Severna Park, MD 21146 Edward P. Macknovitz/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify) Jan. 19, Holy Cross Cemetery Brooklyn Park, MD 2008 21. Signature of Funeral Service Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Failure Immediate Cause (Final disease or condition resulting in death) POVI **Physician** ongest /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to initial accause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed physician ar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown cate has been sig 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy certificate 1□ Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 2 ER/Outpatient 3 DOA Certification: To this 27. Mann of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

ackno

Registrar

1 8 2008



January 15, 2008

Hospital Drive Glen Burnie MD 20161

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Zenani Nonyemeko Mustafa (AKA - Karen Yvonne Carroll) 2008 8:55 January 20, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Stella Maris Hospice Timonium Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 【XF Yrs 26, 1956 Maryland Director 51 217-70-9262 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 XNo Director Montgomery Village Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20404 Lindos Court 20886 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Specify: Black 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Montgomery County (MD) Elementary/Secondary (0-12) College (1-4or 5+) Office Coordinator Executive Office 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be <u>Helen Marie Lyles</u> Calvin Coolidge Carroll, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jabari I. Mustafa, husband 20404 Lindos Court, Montgomery Village, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/24/2008 Germantown, Maryland All Souls Cemetery 21. Signature of Juneral Servic Alicenses 22. Name and Address of Facility Molesworth-Williams Funeral Home 26401 Ridge Road, Damascus, Maryland 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due le or s a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed burial-trar Due to (or as a consequence of) or Vital Records, P.O. Box 68760, physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1☐ Yes 2X No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1☐ Yes 2X No Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 ☐ Yes 2X No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t Division Hospital or Attending 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide n 24 hours after der ne Funeral Directo bletely filled in by th determined 4 Homicide X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical within 24 hou To the Fune completely fi Edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) title of certifier 29b. Signature 1.21-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. EDDIE NAKHUDA 2300 DULANEY VALLEY_RD. TIMONIUM, MD 21093 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar

DHMH 17 Rev 1/2001

ZENANI MUSTAFA

	For State Registrar
1. D€	cedent's

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Or A Director	io Q	Certification:	4 Homicide determine	building, etc. ((Specify)	.,	,,		City or	Town, State)		
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24 h	etaly	Medical	(Check only 2 Medical Ex	aminer: On the basis of ex and manner stated	camination and	or investig	gation, in my o	pinion, death oc	curred at the tir	ne, date and	place, and due	to the cause(s)
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		-	30. Name and address of person w	o completed cause of dear	th (Item 23a) (T	ype, Print)	((6)				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4:23 M 10 2008 January Patricia Lee McKean 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington County Hospital Washington County Hagerstown If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) August 21 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Maryland 82 217-18-7773 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 ☐ No Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 300 Northern Ave. Apt 8A 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fairchild Aircraft Mfg. 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dr. Thurman C. Firey Sarah H. Kreps Firey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Northern Ave. Apt. 8A Hagerstown Maryland 21742 of Disposition (Name of Date 20c. Location - City of Town. State <u> Theodore F. McKean - husband</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town. State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 1-24-2008 Hagerstown Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Advanced disease or condition resulting in death) 200 toa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or as a consequence of) obstructive pulmorum 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? brillahon 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~-: any injury or other traumatte even.

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Division or Vital Records, P.O. Box 68760.

Examine Physician/Medical Completed by Be ၉

Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown

25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Mpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred

1 Accident 5 Pending investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only

29b. Signature and title of certifier a, na 29c. License number D62588 29d. Date signed (Month, Day, Year) 01/21/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUDITH MBAOUA, MA 251 E. Antiemm St. Hagerstown, MA JUDITH MBAOUA, MA

State Registrar

3H-10

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

31. Date filed (Month, Day, Year) **JAN 24**





Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 8:00 P M 17, 2008 January Margulis /Medical Harriet 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Hebrew Home of Greater Washington Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Hours Months Days 1 □ M 2 X F 83^{Yrs} New York Aug. 8, 1924 Director 100-12-3590 Usual Residence of Decedent . 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. It is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1√2 Yes 2 □ No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U. S. A. 20852 6121 Montrose Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No 3altimore, Maryland 21215-0036 Specify: Specify: ģ White 3 ☐ Widowed 4 ☐ Wivorced Completed 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 Year Years Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Unknown) Ginsburg Ruby Greenwald 2 Department of Health and Mimportant; if item 27 in any injury or off-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 60613 19a. Informant's Name/Relationship (Type. Print) 4350 N. Wolcott Ave. Apt. # 3, Chicago, Illinois Beth A. Kanter - Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State King David Mem. Gdns | 1/20/2008 | Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Edward SAge Funeral Direction, Inc. 1091 Rockville Pike, Rockville, Maryland 20852 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each link. Approximate Interval Between Onset and Death CEREBA Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events at the cause) Due to (or as a consequence of) Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical the as IF FEMALE: been signed by the attendin should be detached for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform certificate 1 Yes 2 No Division or Vital Physician: 25. Was case referred to medical examiner? fulneral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) . Marmer of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death. the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled n by 4 Homicide within 24 hours a To the Funeral 6 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29b. Signature and title of certifier 01808/ uenica 30 Name and address of person who completed cause of death (Item 23a) Type, Print)

Registrar
DHMH 17 Rev 1/2001

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31. Date filed (Month, Day Year)

22

2008

NO.

legistrar's Signature

MONTROSE RD.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5:30P O'Connor 15, 2008 Carolyn January Carmen /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel 48 South River Road Edgewater If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year **Funeral** Hours Months Days 1 □ M 2 🕅 F 16. 1940 Washington,DC 67 Jan. 218-36-6942 Director Usual Residence of Decedent death with the Maryland 10d Inside City Limits 10c. City, Town or Location 10a. State 10b, County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No None None Washington, D.C. Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number USA 20036 2017 N Street N.W. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Boat Marina 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Michael O'Connor ပ Carmen Walling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1733 17th St. N.W. Washington, D.C. 20009

ce of Disposition (Name of Date 20c. Location - City or Town, State Patricia L. Smith/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/16/2008 Edgewater, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatur Funeral Service Licensee 2973 Solomons Island Rd. Edgewater, Md. 21037 23a. Part Enter the disease or complications of the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Vears /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ed by the attending physician a detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performe 2□ No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death Fo the Funeral Director: the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my en 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier werm MA DS 2830 January 16, 2008 Best 60 TE RA \$300 annual Me 2/40 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAN 1 8 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 10:58 23 2008 Jani 10179 Charles Raymond Poor Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days 1 M 2 F Director 020-30-4534 69 8/18/1938 Massachusetts Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Yes 2□No Director Maryland | Washington <u>Hagerstown</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 264-268 S. Potomac St. 21740 U.S Funeral A .

14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) Recreation Director State Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles R. Poor Gladys G. Akerly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Α. Poor / Brother 19014 Cherrytree Dr. Hagerstown, Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Smithsburg Crematory 1/26/2008 Smithsburg, Maryland 21. Signator of Funeral Septe Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown Maryland 21742 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Va Physician day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed the attending physician and hed for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 ☐ Other (specify) P.O. | 9☐Unknown 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown has been sig ge 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 20 No page certificate 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA P After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation (Month, Day Year) Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No hours after death Director: A in by the f 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ה 24 hours the Funeral Direct ירי filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ٥ 028365 leu

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Registrar

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istrar's Signature

sheel Heigstam MD21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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JAN 25

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Dav Vear **Physician** 12:20 aM Aleksandr Isaakovich Patlazhan January 20 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F 80 Director 639-38-8023 May 20, 1927 Ukraine Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 K No Director Potomac. Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with U.S.A. 10404 Shepherds Crook Court 20854 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after i Health and Mental Hygiene. em 27 is marked other than "natural", or Itel 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🖺 No Specify. þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Civilian Pilot Russian Military 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ Yitzchak Patlazhan Clara Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Lana Grant - Daughter 10404 Shepherds Crook Court, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Gardens 01/22/2008 Olney, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Silver Spring, Maryland 20904 11800 New Hampshire Avenue, 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 10 minutes Dulmonary /Medical Due to (or as a cons quence of): Examiner Sequentially list conditions, if any, loading to influent decause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ul monary Examiner requires that the death certificate be executed burial-transit two days Hepatic Enceph artipat and Due to (or as a consequence of): physician Box 68760 Physician/Medical the as IF FEMALE for use . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9□Unknown 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy perform 1 Yes 2 No Division or Vital director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. D0065505 20,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHENG 9901 Center Dr. Rockville Medical QIUFANG M.D 31. Date filed (Month, Day, Year) Registrar's Signature State 22 JAN 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 10:00a January 18, 2008 George Neville Palmer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Heartland Healthcare Hyattsville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**153t**M 2□ F Director 67 Dec. 12, Jamaica 578-02-4700 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No notified Director Hyattsville Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code Examiner must be 20782 Jamaica 6103 20th Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Iris Edwards Bertram Palmer ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rodney A. Palmer/Son 6924 100th Avenue, Lanham, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 28. Jan. Mandeville, Manchester, Jamaica 4 ☐ Donation 5 ☐ Other (Specify) Palmer Family Cemetery 2008 21. Signature of Funeral Service Licensee Francis J. Collins Tuneral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Éxaminer 10H8mALL CE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Physician/Medical the as IF FEMALE esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day ó in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be det ð HYPOTHARA BISM 1 Yes 2 No 3 Probably 4 X Unknown Completed certificate Be မ

Box 68760. P.0. Records, Division or Vital After death. neral Director: / hours after within 24 hours a

To the Funeral I

17 (4 - (1) 1)		
		24a. Was an autopsy performed? 1□ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1□ Yes 2 □ No
25. Was case referred to medical	26. Place of Death	(Check only one)
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hon	ne 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury Work? In M 1 Yes 2 □ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying P	ysician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

PARKWAY GREGIEBELT MARYLAND 20770

who completed cause of death (Item 23a) (Type, Print) 325

Year)

31. Date filed (Month, Day, 2 2008 Registrar's Signature

2

State

Registrar

Certification:

Medical

Physician

Funeral

Director

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I

cian	Immediate Cause (Final	_ METASTATIC OVAR	TAN CANCER		Onset and Death
ical iner	disease or condition resulting in death)	Due to (or as a consequence of):	IMW ONWOLK		
je je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of):			
campletely filled in by the funeral director, page 2 should be detached for use as the burial-transit. Medical Certification: To Be Completed by Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		topic pregnancy her (specify)		23d. Date of delivery Month Day Year
ould be deta	Part II. Other significant conditions	contributing to death but not resulting in the under	lying cause given in Part I.		se contribute to the cause of death? ∑ No 3 Probably 4 Unknown
page 2 should	cachexia			24a. Was an autopsy performed? 1∐ Yes 2 ∑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Be (25. Was case referred to medical				
o E	examiner? 1 ☐ Yes 2X No	Hospital: 1 X Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing Ho	ome 5 ☐ Residence	6 □Other (Specify)
e funeral or ation: T	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigatio	"	28c. Injury at Work? M 1 Tyes 2 No	28d. Describe how injur	y occurred
led in by the funera Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		factory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,)
mpletely fille		hysician: To the best of my knowledge, death oc miner: On the basis of examination and/or invest and manner stated.			
\sim	29b. Signature and title of certifier	Tank mo	29c. License number D63579		e signed (Month, Day, Year) .6/2008
8	30. Name and address of person who	completed cause of death (Item 23a) (Type, Prin			

State Registrar

31. Date filed (Month, Day, Year)

JAN 1 7 2008

Maria J. Tayag, 1500 Forest Glen Road, Silver Spring, Maryland 20910 32. Redistrar's Signature & Sperke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 1 8 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 18, 2008 6:10 AM Jon Paul Randolph January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Montgomery Rockville 8. Date of Birth (Month, Day, Year 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Months Days Hours Min. 1 ☐XM 2 ☐ F Nov 13, 1936 Oregon 541-42-8910 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Montgomery Poolesville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20837 18400 River Road 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 2 **X**No 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐No Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Religious Order Buddhist Monk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marie Charlotte Hansen Paul Victor Randolph 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Taliaferro/Executrix 380 Hollowbrook Drive Carlisle, PA 17013 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 01/22/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PROSTATE (AN LER disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an was autopsy performe death? 1 ☐ Yes 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No

Physician /Medical Examiner

be executed

law requires that the death certificate

need

certificate

P.O. Box 68760,

Division or Vital Records,

or Attending Physician;

death.

Director: /

J N. 24 hours S Funeral Div

Medical

and burial-1 physician the as i attending

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

r 28a-f show notified at

7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Magnes.

filed within 72 hours after death with Hygiene.

Baltimore, Maryland 21215-0036

Director

Funeral

þ

Completed

Be

Examine Physician/Medical nse ģ signed by the a Id be detached for þ Completed cate has b After this certification funeral director, p Be P Certification:

1 Yes

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature an

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18/11 KAPLAN 403504 31. Date filed (Month) 2008

5 Pending

investigation

6 Could not be determined

Registrar's Signature

2 ER/Outpatient 3 DOA

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

1 Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

DR

28d. Describe how injury occurred

			For State	State of N	Maryland / Depa	artment of He		, ,	200	0 0010
			Registrar 1. Decedent's Name (First, Midda	fle, Last)	Cei	- Lillicate of D	realli	2. Date of Dea	leg. No. ZUL	3. Time of Death
	Physici /Madi		Mia Rivera	,				Jahuar	Day Ye	
	/Medic		4a. Facility Name (If not institution	on, give street and numbe	er)	4b. City, Town, or I	ocation of Death		4c. County of D	
			Shady Grove A			Rockvil			Montgo	
	uneral		5. Social Security Number	6. Sex 7. / 1 ☐ M 2 ☑ F	Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	, Year)	Birthplace (State or Foreign Country)
	irector		None Usual Residence of Decedent		0 118.	2		Jan. 4,	2008 M	aryland
ryland	how	_	10a. State 10b. County	/	10c. City, Town or Lo	ocation				10d. Inside City Limits
e Ma	Ba-f s stiffed	Directo		gomery	Silver S					1 □Yes 2 ☑ No
with th	or 2 be no		10e. Street and Number	"101		10f. Zip Code		1	log. Citizen of What	
eath	ns 23; must	Funeral	1000 Quebec T	errace #101	nt Ever in U.S. 13	2090		ecify Ves or No-	United S	merican Indian,
fter d	r iten	F	1 ⊠ Never Married 2 Ma	rried Armed Forces	∑ No	Was Decedent of His If Yes, specify Cubar			Black, W	/hite, etc.
UUSO hours af	ral", o Exarr	by	3 ☐ Widowed 4 ☐ Divorce	d If Yes, Give Year or Dates	3:	1⊠Yes 2□No	Specify: E1 Sa	lvadori	an Specify Ot	her
5 Pro	natr	Completed	15. Decede (Specify only high	nt's Education est grade completed)	ı (Give	dent's Usual Occupai kind of work done du	tion		16b. Kind of Busine	
within 5	than '	E G	Elementary/Secondary (0-12)	College (1-4o	r 5+)	DO NOT use retired)			NT	
ING ZIZIS-UUSO be flied within 72 hours after death with the Maryland	ther i	ပို	17. Father's Name (First, Middle		l INC	one	18. Mother's Name	e (First, Middle,	None Maiden Surname)	
id be file	ked o	70 B(Orlando Vill	a Nueva			C1aud	ia Ri	vera	
shou shou	s mar	-	19a. Informant's Name/Relation		19b. Mailir	ng Address (Street ar				e, Zip Code)
and 2	n 27 i		Claudia Rivera	/ Mother		uebec Ter	r. #101,	Silver	Spring,	MD 20903
D Sec 1	Corporation for results and worked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 □Removal from Sta	20b. Place of Dispo cemetery, crei	sition (Name of matory or other place	, '	Date	20c. Location - City	or Town, State
Dallillor permit. Pages	tant:		4 ☐ Donation 5 ☐ Other (Specify)	Fort Linc			1/2008	Brentwo	od, MD
Denal	Important lr		21. Signature of Funeral Service	Licensee		2. Name and Address	•	Simple '		00050
200			23a. Part1. En er the dise se, o shock, or h/ art fai vi e. Lis	or complications that calls	4	040 Rockvi er the mode of dying				Approximate
Phy	sician		Immediate Cause (Final	it only one cause on each	7). (6	,			Interval Between Onset and Death
	ledical		disease or condition resulting in death)	a Due to (or a	as a consequence of):	win				2 days.
Exa	aminer		Sequentially list conditions	Pulma	onary Hem	orthoge				2 days
p	##	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (ur t	as a consequence of):	, 0				
ecute	and I-trans	Examiner	that initiated events resulting in death) Last	c. Hyper	Kalemia (. as a consequence of):	severe)				lay.
cate be executed	physician and s the burial-transit	E E			as a consequence ory.					
00/	g phys	edical		d						
The law requires that the death certification	been signed by the attending properties as should be detached for use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		Testania avangana.			23d. Date of	delivery
deat	ne afte ed for	sicia	in the past 12 months? 1 ☐ Yes 2 No		at time of death 5	Ectopic pregnancy Other (specify)			Month	Day Year
rat the	d by the	Phy	9 Unknown				in Don't	00a Did ta	h	- 4- 41
ires t	signe bed		Part II. Other significant condit	.CY an (al	Henry Vily	nderlying cause giver	ıın Panı.	23e. Did to		e to the cause of death? Probably 4 Unknown
w requires t	peen	eted	Daland duch	tie extens	Todo nej					
he lay	ge 2	Completed by	papere o	MG WHORE	ې د دن			24a. Was a autop: perfor	sy prior	e autopsy findings available to completion of cause of h?
VII.dil	ificate or, pa		25. Was case referred to medical	al			26. Place of Deat		2 No 1 1	
ysicia	is cert direct	o Be	examiner? 1 □ Yes 2 X No	Hospital: 1 Inpa	atient 2 ☐ ER/Outpatier	Othor	**		ence 6 Other (5	Specify)
_ E	fter th neral	n: T	27. Manner of Death ↑ Natural 5 ☐ Pendi	28a. Date of Ir	njury 28b. Time o Day Year) Injury	f 28c. Injury Work			ow injury occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
tending	or: A	catic	2 Accident invest	ligation		M 1□Y	es 2 □ No			
or At	Olrect in by	Certification:		mined 28e. Place of I	injury - At home, farm, str etc. <i>(Specify)</i>	eet, factory, office		28f. Location (S City or Tow	treet and Number o n, State)	r Rural Route Number,
spital	filled		29a. Certifier 1 Certifyi	ing Physician: To the be	st of my knowledge, deat	h occurred at the time	e, date and place.	and due to the o	ause(s) and manne	r as stated
To the Hospital or Attending Physician: within 24 hours after death.	To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical		Examiner: On the basis and manner	of examination and/or in					
To th	To th	Me	29b. Signature and title of certific	er		29c. License	number	2	29d. Date signed (M	onth, Day, Year)
			Man	4	M.D.	432	25		0406/08	?
			30. Name and address of person	n who completed cause of	f death (Item 23a) (Type,	Print)	+10.	alese II	A12 1-0	
			MADIFU NTG 31. Date filed (Month, Day, Year	4m 5h ~d	1 400 VE Adv	entich Hosp	octal, No	chvile	M) 408	<i>ل</i> د
	Sta Registr		JAN 2	2 2008	f death (Item 23a) (Type, f crove Adv strar's Signature	arte				

Physicia /Medic		Gladys May Russ	,					Januar	у Р ^{ау} ,	, 2008	12:30 P
Examin		4a. Facility Name (If not institution, gi Shady Grove Adver				4b. City, Town, c	r Location of Dea	th		County of Death	
Funeral Director		5. Social Security Number 6. 390-14-4080		Age (In yrs. la 86	ast birthday) Yrs.	If Under 1 Year Months Days			h y, Yea <i>r)</i>	9. Birth	place (State or Forei Intry) Consin
show		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limit
a-f sh	tor	Maryland Montgome	ery	Gai	thersb	urg					1 ☐ Yes 2 🕱 N
or 28)ire	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Cou	untry?
ath w	ral	333 Russell Avenu				2087	<u> </u>			ted Sta	
ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Heath and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Deced Armed Forc 1 Tes 2 If Yes, Give Year or Date	es? 2 12 No	1	 13. Was Decedent of Hispanic Origin? (Specify Yes or Not If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify: 			o- 14. Race - American Indian, Black, White, etc. Specify: White		
72 ho natur dical	Completed by	15. Decedent's E (Specify only highest gi	Education rade completed)		16a. Deced	dent's Usual Occup kind of work done OO NOT use retire	ation during most of w	orkina	16b. Kind of Business/Industry		
vithin ne. han "	du d	Elementary/Secondary (0-12)	College (1-4	for 5+)	'life. L		d)	9	0.	wn Home	
12 should be filed within hand Mental Hygiene. 7 Is marked other than traumatic event, the Med	To Be Co	17. Father's Name (<i>First, Middle, Las</i> Charles Loyda	z)		пошеш	akei	18. Mother's Na Elsie B	ume (First, Middle, Sulin			
shou and M s mar		19a. Informant's Name/Relationship	(Type. Print)		19b. Mailin	g Address (Street	and Number or F	Rural Route Numbe	er, City or	Town, State, Z.	ip Code)
1 and 2 Health em 27 I		William K. Russ	(Son)					Village	s, Fl	Lorida :	32162
permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 [4 □ Donation 5 □ XOther (Spec	□Removal from St	20b. Plate Gainent Cemo	ace of Dispos emetery, cren te of etery	sition <i>(Name of</i> natory or other pla Heaven Mausoleu	ce) Jan m 2	uary 21,		eation - City or T	own, State
Departi Departi Importi any inj once.		21. Signature of Funeral Service Lice		X	22	. Name and Addre	ss of Facility	DeVol Fu			W. O
0.05 60	-	23a. Part1 Ent 7 the disease or cor shock or heart altire. List only	1) UV	W				ive, Gai		sburg, l	
	М		Approximate Interval Between Onset and Death								
Physician /Medical		Immediate (a) (Final disease or contition resulting in death)	a	ary Fa							
Examiner			,	c Obst	-	e Pulmon	arv Dise	ase			
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cuted nd transit	Examiner	Cause (Disease or injury that initiated events	C								
		resulting in death) Last	Due to (or ▲d.	r as a consequ	ence of):						
ertifica ling ph e as t	Med	IF FEMALE:	00.11						-1		0 (===
000	ysician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		th 2 ☐ Fetal nt at time of de	death 3	lEctopic pregnanc Other (specify) _	у		23	3d. Date of deliv Month	very Day Year
requires that the	y Phys	Part II. Other significant conditions	contributing to dea	th but not resul	Iting in the un	nderlying cause giv	ren in Part I.	23e. Did to	obacco us	e contribute to	the cause of death?
quires in sign	od by							1 📗	∕es 2⊑]No 3□Pro	babiy 4 😾 Unknow
e law has b je 2 si	Completed									24b. Were aut prior to co death? 1 □ Yes	copsy findings availab completion of cause of
ician: Th certificate ector, pag	Bec	25. Was case referred to medical examiner?					26. Place of De	eath (Check only o		12100	
isi ig	٥	1 Yes 2 No		oatient 2 🗆 E			er: 4 Nursing	Home 5 ☐ Resid	dence 6	□Other (Spec	ify)
ding P. After fune	Certification:	27. Manner of Death 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be	on .	Day Year)	28b. Time of Injury	M 1□	ry at k? Yes 2 □ No	28d. Describe h			
Hospital or Attended hours after death Funeral Director: tely filled in by the		4 ☐ Homicide determined	building	g, etc. (Specify))	eet, factory, office		City or Tov	vn, State)		ral Route Number,
	edical	(Check only 2 Medical Exa	hysician: To the base miner: On the base and manne	is of examinati	vledge, death on and/or inv	vestigation, in my	opinion, death oc	ce, and due to the curred at the time,	cause(s) a date and	and manner as place, and due	stated. to the cause(s)
To the To the Comple	2	29b. Signature and title of certifier				29c. Licens				signed (Month	, Day, Year)
V		MD 20064560						>	JANUARY 17,2008		
		50. Name and address of person who Nidhi Singh Nikh					r Drive,	Rockvil	le, l	MD 2085	0
Stat Registra		31. Date filed (Month, Day, Year) JAN 2 2 20	100	gistrar's Signatu	240	els)					

Funeral Director Social Security Number 5. Social Sec	4:20 P M
Medical Examiner Samuel Thomas Rolls January 19,2008	4:20 P M eath Comery Birthplace (State or Foreign Country)
Holy Cross Hospital Silver Spring Mont Funeral Director 5. Social Security Number 6. Sex 1 Monts Days Hours Min. (Month, Day, Year) Usual Residence of Decedent Silver Spring Month Days Hours Min. (Month, Day, Year) Dec. 2, 1909	topomery Birthplace (State or Foreign Country)
Funeral Director 5. Social Security Number 5. Social Security Number 5. Social Security Number 1	Birthplace (State or Foreign Country)
Director 578-46-8172 1 M 2 F 98 Yrs. Months Days Hours Min. (Month, Day, Year) Dec. 2, 1909 Usual Residence of Decedent	Country)
Usual Residence of Decedent	Georgia
Maryland Montgomery Silver Spring 10e. Street and Number 9409 Wire Avenue 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes specify Cuben Mexican Plants Bloop etc.) 14. Race - Armed Forces?	10d. Inside City Limits
10e. Street and Number 9409 Wire Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes specify Cuben Mexican Plants Blant and Number USA) 14. Race - Armed Forces?	1 ☐ Yes 2 ☑ No
9409 Wire Avenue 9409 Wire Avenue 20901 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Hyas precify Cuben Maying Plants Bloom of No-It Agac - Armed Forces?	Country?
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Ever in U.S. If Yes specify Cities Maying Plants Bloom do No-	
Armed Forces? If Yas enactify Cultur Maying Duarto Digan ata \	nerican Indian,
Slack, William 1 □ Never Married 2 □ Married 1 □ Rey Superior 1 □ Never Married 2	hite, etc.
Specify: WIT 1 Yes 2 No Specify: WIT 1 Yes 2 No Specify: WIT 1 Specify: WIT 1 Yes 2 No Specify: WIT 1 Specify:	nite
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busines (Give kind of work one during most of working life. DO NOT use retired) 17b. Elementary/Secondary (0-12) 18c. Visual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18c. Visual Occupation (Give kind of work one during most of working life. DO NOT use retired) 18c. Visual Occupation (Give kind of work one during most of working life. DO NOT use retired) 18c. Visual Occupation (Give kind of work one during most of working life. DO NOT use retired) 18c. Visual Occupation (Give kind of work one during most of working life. DO NOT use retired)	ss/Industry
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Figure Cable Tel	evision
Table 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
Nathan Rolls Mattie L. Chapman	
19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State	e, Zip Code)
John Marcus Rolls/Son 19336 Hempstone Avenue, Poolesville, MD 20837	
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1	or Town, State
1 Burial 2 kpCremation 3 Removal from State January 21, 4 Donation 5 Other (Specify) Metropolitan Crematory 2008 Alexandria,	Virginia
John Marcus Rolls/Son 19336 Hempstone Avenue, Poolesville, MD 20837 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility 22. Name and Address of Facility 23. Signature of Funeral Service Licensee 22. Name and Address of Facility 23. Signature of Funeral Home Inc.	7 - 1 - 9 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1
Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD	20901
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between
Immediate Cause (Final	Onset and Death
/Medical disease or condition resulting in death) disease or condition resulting in death) Sertic Shock Due to (or as a consequence of):	
Examiner Sequentially list conditions Pneumonia	
Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
The sulting in death) Last Due to (or as a consequence of):	
d	
FFEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of companion of the past 12 months? 23d. Date of companion of the past 12 months?	
in the past 12 months? Description of the past 12 months 1	Day Year
the part of the pa	
	to the cause of death?
1 Yes 2 No 3	Probably 4₺Unknown
1 Yes 2 No 3 1 Yes 2 No 3 24a. Was an autopsy performed? death 1 Yes 2 Xea No 1 Yes 2	autopsy findings available o completion of cause of
A S S C S C S C S C S C S C S C S C S C	
1 Yes 2 1 No 1 Yes 2 1 Yes	
, ≥ © 0 2 1 165 25 Nursing Home 5 Residence 6 Other (St	pecify)
↑ ± m · · · · · · · · · · · · · · · · · ·	
27. Manner of Death 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28b. Time of Injury 28	
The standard of the standard o	Rural Route Number,
building, etc. (Specify) City or Town, State)	
	as stated.
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Max.)	ue to the cause(s)
29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo	nth, Day, Year)
D50209 January 19,	2008
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
Brian C. Shen, MD 1500 Forest Glen Road, Silver Spring, MD 20910	
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State Registrar 31. Date filed (Month, Day, Year) JAN 2 2 2008 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 0630 AM JAN 2008 Melissa Rivera 14 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🛣 F Months Days Hours Min. Jan. 4, 2008 Maryland Director 10 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the M-dical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 1000 Quebec Terrace #101 20903 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 ☐ Married t⊈Yes 2□No Specify: E1 Salvadorian 3altimore, Maryland 21215-0036 <u>6</u> 3 ☐ Widowed 4 ☐ Divorced Other Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Orlando Villa Nueva Claudia Rivera 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claudia Rivera / Mother 1000 Quebec Terr. #101, Si1ver Spring, MD 2090320b. Place of Disposition (Name of cemetery, crematory or other place) Date. 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【ICremation 3 ☐ Removal from State Fort Lincoln Crematory 1/21/2008 | Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 **Physician** /Medical Due to (or as a consequence of) Examiner hemorrhy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ng physician and as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical actrem. IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 No Month Day 4□Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes > No 3 ☐ Probably 4 ☐ Unknown Intraventrecular 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 | Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Natural 2 ☐ Accident Injury 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 51461

Registrar

DHMH 17 Rev 1/2001

State

9901 Medical Center Dr. Rockville, Mis 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rost

32 Registrar's Signature

U.D

Robert

2 2 2008

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Reyes Juan January 16, 2008 10:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14209 Rippling Brook Drive Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Director 579-54-8847 79 \$ept. 4, 1928 Mexico Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene.

s marked other than "natural", or items 23a or 28a-f show 10a, State 10c. City, Town or Location 10b. County 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐Yes 2X No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12609 Goodhill Road 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married I ☐ Yes 2 f Yes, Give 2 **N**O 1 x Yes 2 □ No Completed by Specify: Mexican Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Technician Heating & Air Conditioning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Felipe Reyes Luz Rodriguez 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Angelina Gamez Reyes/Wife 12609 Goodhill Road, Silver Spring, MD 20906 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o Jan. 18, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Gate of Heaven Cemetery 2008 Silver Spring, Maryland 21. Signature of Funera(Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) a.Respiratory Failure 6 Months /Medical Due to (or as a consequence of) Examiner Chronic Obstructive Pulmonary Disease 1 Year Sequentially list conditions, it any, I sading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting is death) I get Examiner The law requires that the death certificate be executed as the burial-transit attending physician and resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 1□ Yes 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: $_{4}$ Nursing Home $_{5}$ Residence $_{6}$ Other (Specify)Daughter's Hospital: 2 1 ☐ Yes 2 ☑ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? e Hospital or Attending P 24 hours after death. e Funeral Director: After t letely filled in by the funera 28d. Describe how injury occurred After Residence 1 🔀 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D27985 January 17, 2008 Ullina 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William H. Silverman, MD 1201 Seven Locks Road, #211, Rockville, MD 20854 31. Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

			for State Registrar AMEND#22	St perFH1	tate of 123/0	Maryland 18, BMW, I	d / Depa MoC <i>6ei</i>	artment rtificate	of H	ealth a Death	and M	ental H	lygier Reg. N		8 0	03	
	13.3		1. Decedent's Name (First, Midd						2. Date of	Death			3. Time of	Death			
	Physici /Medic		Anna Clark E	Reed-Pe	eters	on						Month Jan.	1	,	rear 8	10:15	Р.М.
	Examir		4a. Facility Name (If not institution	on, give stree	t and numb	er)		4b. City, 1	Town, or	Location of	of Death		4	c. County of	Death		
			Casey House Mo	ntgome	ery Ho	ospic		Rocky					1	Montgo	mer	У	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M		Age (In yrs. Ia	34	If Under	1 Year Days	If Under Hours	Min.	8. Date of (Month,	Day, Yea	(r)	Cour		
	Director		251-36-7688	1	200	8	O Yrs.					June_	11,	1927 A	bbe	ville,	S.C.
	and		Usual Residence of Decedent 10a. State 10b. Count	У		10c. City	, Town or Lo	cation							1	0d. Inside Ci	itv Limits
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	the 28a-	Director	10e. Street and Number	N/A		W	ashing	10f. Zip	Code				10a. 0	Citizen of Wh	nat Cour	ntry?	
	3a or	Ö	115 Seaton Pl	ace. N	M.			200						.s.		•	
	ms 2	Funeral	11. Marital Status	12. V	Vas Decede	ent Ever in U.S		Was Deced	ent of His	spanic On	gin? (Spe	cify Yes or		14. Race -			
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	rried 1	Armed Force ☐ Yes 2 If Yes, Give / ear or Date	□ NoX		lf Yes, spec 1 ☐ Yes	_	Specify:	n, Puerto I	Rican, etc.)		Black, Specify:	White,	etc. roAme:	r.
Ö	2 hou	ted	15. Decede	nt's Educatio	n		16a. Deced	lent's Usua	Occupa	tion			16b.	Kind of Busi	iness/In	dustry	
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2	yd wil	Sol	12				_Child	l Care	•					Priva	te		
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Maryland	12 sh hand 7 Is m traum		19a. Informant's Name/Relation Julia Dunkins			•		_						or Town, Si D · C ·		•	
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Ba	Depar Impor any Ir		Moma	. 19 (Visto	un										200	
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complication	ons that cau	sed the death.										Approximat	e
	Physician		Immediate Cause (Final	st only one ca		Renal										Interval Bet Onset and I	Death
k.	/Medical		disease or condition resulting in death)	a	Due to (or	as a conseque	ence of):								_		
ш	Examiner		Sequentially list conditions	b	Conge	stive	Heart	Failu	ıre								
	₽ .≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events are ultimis depth) lead	,	Due to (or	as a conseque	ence of):					-					
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Вох	death certific e attending p d for use as	Physician/Me	23b. Was decedent pregnant in the past 12-months?	1	I ☐Live birt	h 2□Fetal nt at time of de	death 3□	Ectopic pre						23d. Date Mont			Year
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Vital		Be C	25. Was case referred to medic examiner?	al						26. Place	of Death	(Check on		40 12		20110	
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Division	I or Attend after death. Director: A	Certification:		mined 28	building	injury - At hon , etc. <i>(Specify)</i>	ne, tarm, str	eet, factory,	, office		2		n (Street Town, Ste		or Rura	al Route Num	nber,
	ospital hours a uneral		29a. Certifier / 14 Certify	Ing Physicia	n: To the bi	est of my know	/ledge, death	occurred :	at the tim	e date ar	nd place a	and due to t	he cause	(s) and man	nar as s	tated	
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical	(Check only one) 2 Medica	I Examiner:	On the bas	is of examinati	on and/or in	vestigation,	in my op	inion, dea	ath occurre	ed at the tir	ne, date a	and place, an	nd due t	o the cause(s	s)
	To the Hwithin 24 To the Fi	Me	29b. Signature and title of certifi		10			29c.	License	number			29d. [Date signed (Month,	Day, Year)	
	la		> Irluneni	WAG	lew	Ski un	al	1	00064	4615			Jan	. 18,	200	8	
	Ψ		30. Name and address of person	n who comple	eted cause	of death (Item	23a) (Type,	Print)									
_			Genieve Wrobl	ewski,	M.D.	, 6001	Munca	ster	Mill	Road	d, Ro	ckvil	le,	MD 208	355		
	Sta		31. Date filed (Month, Day, Year	7)	32 Reg	istrar's Signatu	ure	AL.									
	Registr	ar	JAN 22	2008	1 9 An	w S.	And the										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** JANUARY 2008 11:26 16 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical M D Under 24 Hrs. Hours Min. zea ional ISDUM 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace Country) (State or Foreign **Funeral** 1□M 2€F Months Days 217 52 0030 Usual Residence of Decedent Director 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits iral", or Items 23a or 28a-f shov Examiner must be notified at Director 1 ☐ Yes 2 No emoker 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No. Specify: þ Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation event, the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NQT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n: any Injury or other traumatic event, the Media once. Elementary/Secondary (0-12) College (1-4or 5+) Abover 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ORKS. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) V DAUGHTER Dudley AV-BRundwater -CITY ANDORA 20b. Place of Disposition (Name of cemetery, crematory or other place) occomobe md 21851 20a. Method of Disposition PEBurial 2 ☐ Cremation 3 ☐ Removal from State Polamoke City mel 285 23-68 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility L. HARton 21. Signature of Funeral Service Lice unageton Rd ACCOMPC VC 23361 23a. Part1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LIVER Metastases Physician disease or condition resulting in death) /Medical Pleural Effusion Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Breat Cancer ecurren Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Year Day 5 ☐ Other (specify) 1 Ves 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pertension 1 Yes 2 No 3 Probably Audinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Inpatient 28a. Date of Injury Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ② No 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 1 Natural 2 ☐ Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Examiner the death certificate be executed the burial-tra attending physician use as t P.O. signed by the or Vital Records, page 2 should be certificate this

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

28a-f show

"natural",

After

or Attending death. within 24 hours after death To the Funeral Director; filled in by

completely

State Registrar

29c. License number

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name address of pers in who completed cause ath (Item 23a) (Type, Print)

arroll St. Salisbury, m.D. 21804 101 100

31. Date filed (Month) Year) 2

(Check only one)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 16, 2008 Year 11:22 PM Nancy Sohl Jan. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□M 2\\ F Months Days Hours 77 165-24-8169 Feb. 16, 1930 Pennsylvania Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Arnold 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1441A Grandview Road 21012 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ▼No Specify White Specify: 3 Widowed 4 Noivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Chief of Staff on Capitol Hill Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James McCarty Gertrude McCoy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6436 Scrivner Court Friendship, Maryland 20758 Judith G. Whitbred/ Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date n - 21, 2008 *,* 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Baltimore, Maryland 21. Signature of Funeral Service Licen Barranco & Sons, P.A. Severna Park Funeral Home Romo 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pheumoma Weeks Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
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4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

Physician /Medical **Examiner** Examine that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be ready Injury or other traumatic event, the Medical Examiner must be reader.

Baltimore, Maryland 21215-0036

r 28a-f show notified at

Director

Funeral

þ

Completed

Be

ပ

MD

burialattending properties for use as ģ page 2 certificate has this

Physician/Medical Completed Be Certification: To

funeral director, after death Director: filled in by

Division or Vital Records, P.O. Box 68760

or Attending

Hospital

24 hours a completely the

Medical

Registrar

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier HudBeck, MD

D46052

28c. Injury at Work?

1 🗖 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a), (Type, Print) and Poulway, anapolity, Mb Slothor

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

31. Date filed (Month, Day, Year)

JAN 1 8 2008

5 Pending investigation

6 Could not be determined

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 008 Year Janth. 18, Esther Louise Shirley 3:30p M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington 13829 Charlton Court Clear Spring, 9. Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-8-1929 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Days Hours 217-32-6486 1 □ M 2√2 F 78 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Washington Clear Spring, 1 ☐ Yes 2 🖫 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13829 Charleton Court 21722 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married SpeWhite 1 ☐ Yes 2X No Specify: 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry residence Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earl L. Small Naomi Hawbaker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2541919a, Informant's Name/Relationship (Type, Print) Ernest L. Shirley 18048 Nestle Quarry Rd. Falling Waters, WV son 20b. Place of Disposition (Name of Jan. 23, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Shanktown Cemetery Big Pool, MD 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc P.O.BOX 310 Clear Spring, MD 21722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 4 car disease or condition resulting in death) holans 10 Carcinon Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, signed by the at d be detached for page 2 s has To the Hospital or Attanding Physician: To the

Physician

Funeral

Director

r than "natural", or Items 23e or 28a-f show the Medical Examinar must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: If itam 27 Is marked other than

permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Importent: If itam 27 Is marked other th eny injury or other traumatic avant, III. 2002.

Physician

/Medical

Examiner

/Medical

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

32. Raistrar's Signature JAN 24

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month ELLWOOD STANLEY SMITH, JR. /Medical JANUARY 20, 2008 6:17 P 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CHESTER OUEEN ANNE'S **406 DOMINION ROAD** 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**X** M 2□ F JUNE 19, Director 56 MARYLAND 216-54-9644 1951 Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Director MARYLAND QUEEN ANNE'S CHESTER 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ortant: If Item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be a UNITED STATES 406 DOMINION ROAD 21619 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes 2 🗷 No 2 Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Q WATERMAN SEAFOOD Jih and Mental Hvr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ELLWOOD STANLEY SMITH, SR. MARY LEONA CLARK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau EDNA CATHERINE SMITH/WIFE 406 DOMINION ROAD, CHESTER, MARYLAND 21619 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 JANUARY 23 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Dother STEVENSVILLE CEMETERY STEVENSVILLE, MARYLAND 2008 21. Signature of Funeral sice Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 e or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the shock, or hear Immediate Cause (Final disease or condition resulting in death) **Physician** ntra henatic /Medical Due to (or as a consequence of Examiner Sequentially list conditions, in the light cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of executed Due to (or as a consequence of): Box 68760, certificate be Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>Ş</u> 1 ☐ Yes 2 0 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy performed? Yes 2D No certificate 1□ Yes **Division or Vital** 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours after Funeral 1 Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Registrar

State

the within To the

29b. Signature and title of certifier

MARY DESHIELDS,

PURDY STREET,

29c. License number

EASTON, MARYLAND 21601

29d. Date signed (Month, Day, Year)

00

and manner stated.

401

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 16, JAN. 2008 8:05 AM MARION W. SPENCE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MONTGOMERY 7816 Rydal Terrace Derwood If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Dec. 28, 1911 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
N. Carolina **Funeral** 1□ M 2√2 F 96 Months 238-58-8369 Director Usual Residence of Decedent 10a. State 10c. Cify, Town or Location 10b. County 10d. Inside City Limits 28a-f sh notified MD 1 XYes 2 No Director Montgomery Derwood death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or ms 23a 7816 Rydal Terrace 20855 Funeral U.S.A. r than "natural", or items the Medical Examiner ma 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify þ Specify: Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Edgecombe Co. Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Schools yrs other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fil Health and Mental H tem 27 Is marked oth Be Garfield Williams ၉ Margaret Hinton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Laurann Wynn (Daughter) 7816 Rydal Terrace, Derwood, MD 20855 other 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 Department of the Important: If Ite any injury or of once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Westlawn Cemetery 1/19/08 4 Donation 5 Dother (Specify) Elizabeth City, NC Signatur Truneral Service Licens 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. DEME Washington St, Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 3 yrs disease or condition resulting in death) Dysphogia /Medical Due to (or as a consequence of): Examiner Stroke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed Hypertension as the burial-tra Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a O 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ cate has been sig Diabetes 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? 1 ☐ Yes perforn 2XXX 2 No Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home SX Residence 6 ☐ Other (Specify) 1 Yes 2 100 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) 1X Natural death. 1 ☐ Yes 2 ☐ No s after death, 2 Accident filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or within 24 hours a

To the Funeral I 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 5 29b, Signature and title of certifier 29d. Date signed (Month, Day, Year) m.O. MO DOU34726 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jasmine C, Gatti, Bethesda 302 2081 8218

State Registrar 31. Date filed (Month, Day,

NAL

Year

2008

22

32 egistrar's Signature

			For State Registrar	State of Maryland		artment of F		Mental Hy	giene Reg. No	2000	2 03	117
		84	Decedent's Name (First, Middle	, Last)				2. Date of De	ath		3. Time of	Death
	Physici /Medic		Ethel Mae	Sparrough				Janua:	ry 1		8:25	\mathbf{p}^{M}
	Examir		4a. Facility Name (If not institution	, give street and number)		4b. City, Town, o	r Location of Dea	ith	4c.	County of Dear	th	
	Funeval		Renaissance Ga 5. Social Security Number	ardens at Riderwo 6. Sex 7. Age (In yrs. la		Llage If Under 1 Year	Silver	Spring 8. Date of Bir	th		e George	
к	Funeral Director		577-20-6164	1□ M 2□ x F 87	Yrs.	Months Days	Hours Min	. (Month, Da	y, Year)	920 Was	ountry)	0
	pu ,		Usual Residence of Decedent		T			Aug. Z.	2, 1	920 Was	151	
	h the Marylan r 28a-f show notified at	o	10a. State 10b. County	Toc. City,	Town or Lo	cation					10d. Inside Cit 1 ☐ Yes	,
	the N 28a-i	Director	Maryland 10e. Street and Number	Montgomery	-	Silver S	pring		10a Citi	izen of What Co		
	hours after death with the Maryland tural", or Items 23a or 28a-f show al Examiner must be notified at	iO le	13713 Stoner D	rive		20904			USA	2011 07 771141 00	variary.	
	items ?	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	13.	Uas Decedent of H Yes, specify Cuba	lispanic Origin? (Specify Yes or No)-	14. Race - Ame		
36	s after , or its amine		1 Never Married 2 Marrie	If Yes, Give		i □ Yes 2□ No	Specify:	nto mean, etc.)		Black, Whit		
21215-0036	hours turai'	ed by	₩idowed 4 Divorced	Year or Dates:		ent's Usual Occup			16h Vi	SpecifyWhi		
15	nin 72 n "nat Medica	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed)	(Give	kind of work done	during most of wo	orking	100. K	ind of business/	industry	
212	e filed within al Hygiene. I other than " vent, the Med	mo	12	College (1-4or 5+)	lerk				Reta	ail/Banl	cina	
pu	al Hy Jothe	Be (17. Father's Name (First, Middle, I					me (First, Middle	Maiden			
yla	2 should be and Mental I s marked o raumatic eve	6	Olin A. T. Hor					ae Spitze				
Maryland	s 1 and 2 should be filed within 72 hours after d if Health and Mental Hyglene. Item 27 Is marked other than "natural", or Iten other traumatic event, the Medical Examiner		19a. Informant's Name/Relationsh Regina M. Chic			g Address (Street						
	1 and Healt tem 2		20a. Method of Disposition	20b. Pla	ace of Dispo	.3713 Sto		Date		oring, I		1
altimore,			1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp	3 Li Removai from State		natory or other plac	, our	·				
altii	permit. Page Department of Important: If any injury or once.	1	21. Signature of Funeral Service L	1201	22	oln Ceme . Name and Addre	ss of Facility	008		Brentwoo		
m	Depar Depar Impor any ir		James 5	Dalon	Fr	ancis J. O Univer	Collins	Funeral	Hon	ne Inc.	ng. MD 2	20901
r			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caused the death.	Do not ente	er the mode of dyin	ng, such as cardia	ac or respiratory a	rrest,		Approximate Interval Betv	veen
1	Physician	Ì	Immediate Cause (Final disease or condition resulting in death)	_a Chronic Kidne	ey Dis	ease					Onset and D	eath
	/Medical Examiner		resulting in death)	Due to (or as a conseque								
		e.	Sequentially list conditions,	b. Diabetes Mell							10 Yea	ars
Ь	outed d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
Ö	certificate be executed ding physician and se as the burial-transit	Exa	resulting in death) Last	Due to (or as a conseque	ence of):	****						
8760,	ate be hysici the bu	edical	'									
9 ×	eath certifica attending ph for use as t	/Мес	IF FEMALE:	23a If you guttoome of program								
Box	eath o	cian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregnand 1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3□	Ectopic pregnancy Other (specify)	/		1	23d. Date of del Month	,	ear
0	the d	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	atti 5 _	Other (apecity)						
S,	law requires that the death as been signed by the atter 2 should be detached for u	by PI	Part II. Other significant condition	ns contributing to death but not result	ting in the ur	derlying cause give	en in Part I.	23e. Did t	obacco u	ise contribute to	the cause of de	eath?
Records,	w require been sig							10	Yes 2≹	No 3□Pr	obably 4 □U	nknown
ecc	has be	Completed						24a. Was		24b. Were au	topsy findings a	vailable
	ate ⊐	Con						perfo 1□ Yes	rmed?	death?	·_	.400 01
Vital	Physician: this certificatal director,	Be	25. Was case referred to medical examiner?	Hospital:		l out		ath (Check only c				
o	Phys this ral dir	۲.	1 ☐ Yes 2X No 27. Manner of Death	1 Inpatient 2 E	R/Outpatient 28b. Time of		4 LA Nursing	Home 5 Resid			cify)	
	Attending Ph r death. ector: After thi by the funeral	tion	1 ₺ Natural 5 Pending 2 Accident investiga	(Month, Day Year)	Injury	Worl	yan k? Yes 2 ∐ No	28d. Describe I	now injui	y occurred		
Division	al or Attendli after death. I Director: A d in by the fu	ifica	3 Suicide 6 Could not determine	ot be 28e. Place of injury - At hom	ne, farm, stre			28f. Location (Street an	d Number or Ru	ıral Route Numb	per,
D	tal or Att s after de al Direct ed in by 1	Certification:	4 Horricide	building, etc. (Specify)				City or Tox	vn, State)		
	To the Hospital of within 24 hours at To the Funeral D completely filled i		Check billy Z Medical E	Physician: To the best of my knowlessaminer: On the basis of examination	ledge, death	occurred at the tir	ne, date and place	e, and due to the	cause(s)	and manner as	stated.	
	To the Ho within 24 I To the Fu completely	Medical	one) 29b. Signature and title of confider.	and manner stated.		29c. License						
	N × × × ×		200. Signature and the confidence	11		D24093				e signed (Mont		
	(3)		30. Name and address of person w	vho completed cause of death (Item 2	23a) (Type	Print)			oan.	18, 20		
	,		Mark Parkhurst,				lver Spr	ing, MD	2090	4		
	Sta Registr	e	31. Date filed (Month, Day, Year)	37 Registrar's Signatu		ali s		No.				

			For State Registrar	State	of Marylar		artment rtificate			and M	ental Hy	giene Reg. No.	2008	03	118
	Physici	an	1. Decedent's Name (First, Mide								2. Date of De		Year	3. Time of	
	/Medi	cal	Eva N 4a. Facility Name (If not instituti				4b. City, T	own or L	ocation of		Januar	y 18	2008 County of Death	3:20	P^{M}
	Examir	ier	Casey House	on, give once and	riambery			ckvi		Death			Montgom		
- 3.4	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1				8. Date of Bir	of Birth 9. Birthplace (State or			
В	Director		220-32-6597	1□M 2🌠 I	70	Yrs.	Months	Days	Hours	Min.		March 7,1937 Couintry) VA			
	and w		Usual Residence of Decedent 10a. State 10b. Count	v	10c. Cit	ty, Town or Lo	cation							10d. Inside Ci	ity Limite
	Maryl f sho led at	ō													2 No
	r 28a-	Director	MD Mont 10e. Street and Number	gomery			10f. Zip C		burg	-		10g. Citize	en of What Cou	intry?	
	h with		211 Cedar A	venue				208	77				ited St		
	ems ser unu	Funeral	11. Marital Status		Decedent Ever in U	.S. 13.	Was Decede	nt of Hisp	panic Orig	gin? (Spec	cify Yes or No Rican, etc.))- 14	4. Race - Ameri		
98	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or ftems 23a or 28a-f show ent, the Medical Examiner must be notified at		1 Never Married 2 Ma	rried 1 TYes,	es 2 No Give		1 ☐ Yes 2		Specify:	, ruello r	nican, etc.)		Black, White Specify: Wh	, etc. ite	
21215-0036	hours tural"	d by	3 XWidowed 4 ☐ Divorce	d Year o	r Dates:										
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þ	othe othe	Bec	17. Father's Name (First, Middle	, Last)		11411121	110010				(First, Middle	, Maiden S			
/lar	uld by Ments rrked	TO E	William Cla	yborne					(Carr	ie Moni	roe			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relation		1 4.								Town, State, Zi	p Code)	**
e)	1 and Health Im 27 ther to	13	Michelle A. Se	rby/Daug					e, Mo		Airy,				
Baltimore,	ages nt of h if ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation			Place of Dispo cemetery, cren rnestov	natorv or oth	er place))	Janı		20c. Loc	ation - City or T	own, State	
를	iit. Partmel		4 □ Donation 5 □ Other (21. Signature of Funeral Service			esbytei					2008	Gai	thersbu	rg, MD	
Ba	Depa Impo		TRACTAS	Than)							ne, 10	East	Deer P MD 2087	ark Dr	ive,
i)			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications the	at caused the deat	h. Do not ente	er the mode	of dying,	such as o	cardiac or	respiratory a	rrest,	MD 208/	Approximat	e
	Physician	21. 19	Immediate Cause (Final disease or condition	tonly one cause c		er of U	Iterus							Interval Bet Onset and I	
	/Medical		resulting in death)	a. Due	to (or as a conseq		, , ,								
	Examiner	L	Sequentially list conditions.	b											
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due	to (or as a conseq	uence of):									
	xecut and	хап	that initiated events resulting in death) Last	c	to (or as a conseq	uence of):									
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9	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edic		d.								77	ĺ		
Box	leath certific attending p for use as	In/M	IF FEMALE: 23b. Was decedent pregnant		outcome pf pregna		Tatania ass					23	d. Date of deliv	rery	
E	e deat	Physician/Med	in the past 12 months? 1 ☐ Yes 2 🛣 No	4□Pr	egnant at time of di known		Ectopic pred Other (spec						Month	Day	Year
<u>Р</u>	w requires that the d been signed by the should be detached	Phy	9 Unknown			uld to de co									
Vital Records, P.O.	ires the signer	ρ	Part II. Other significant condit Chronic Obst					se given	in Part I.				e contribute to t No 3☐ Pro		
Ö	v requ	Completed				, 22300									
æ	ne lav has ge 2 ş	mpl								_	24a. Was autop		24b. Were auto prior to co death?	opsy findings ompletion of c	available ause of
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	/sicia	To Be	examiner? 1 ☐ Yes 2X No	Hospital:	☐ Inpatient 2 ☐	FB/Outpatien	1 3 DOA	045			Check onl		☑Other (Speci	4) Hogo	
Division or	ding Phy h. After thi funeral		27. Manner of Death	28a. Da	ate of Injury Ionth, Day Year)	28b. Time of		Injury a Work?			Bd. Describe I		**	<i>у</i> поѕр	ice
000	tendir leath. tor: Af the fur	atio	Z LI Accident	igation	onin, bay reary	пдагу	м		s 2⊡N	lo					
Š	or Attenatiter death Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Pla	ace of injury - At ho ilding, etc. (Specif		eet, factory,	office		28	Bf. Location (S City or Tox	Street and vn, State)	Number or Rur	al Route Num	ber,
	ospital or / hours after uneral Dire ly filled in b		00- O												
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, I	Medical	29a. Certifier 1 Certifyl (Check only one) 2 Medica	ng Physician: To I Examiner: On the	the best of my kno e basis of examina anner stated.	wiedge, death ition and/or inv	occurred at estigation, i	the time, n my opin	, date and nion, deat	d place, au h occurre	nd due to the d at the time,	cause(s) a date and p	ind manner as solace, and due t	stated. to the cause(s	;)
	o the	Med	29b. Signature and title of certifi		A)		29c. I	_icense n	number			29d. Date	signed (Month,	Day, Year)	
,	/		> Kremen	e Widde	Ewsic.	bus	DO	00646	615				nuary 20		3
3	>	ŀ	30. Name and address of person	00/	ause of death (Item	1 23a) (Type, I	Print)								
			Genebieve Wro				card 1	rive	e, Su	iite	100, R	lockvi	ille, M	20850)
	Sta		31. Date filed (Month, Day, Year JAN 2	2000	gistrar's Signa	ture	ast a								
	Registr	ar	JAN 27	2008	MANUEL 1	U AD									

Registrar DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) JAN 22

600 N WOLFE ST

gistrar's Signature

		1	For State Registra AMEND#20a, b, 0		aryland / Der				giene 2008	03120
			1. Decedent's Name (First, Middle, I		3/11/11/12/2000			2. Date of Dea	ıth	3. Time of Death
	Physicia		Raymond Lightne		Jr.			January	15, 2008	3:15 p M
	/Medic	al	ta. Facility Name (If not institution, g			4b. City, Town, or	Location of Dea		4c. County of Dea	th
) k . —	Examin	er	Holy Cross Hos			Silver S	pring		Mont	gomery
			_		ge (In yrs. last birthda	y) If Under 1 Year	If Under 24 Hr		(Year) Co	thplace (State or Foreign
	Funeral Director		213-76-0156	M 2 □ F	77 Yrs.	Months Days	Hours Mir	Sept. 2	24, 1930 Pe	nnsylvania
10		-	Usual Residence of Decedent							10d. Inside City Limits
	yland at		10a. State 10b. County		10c. City, Town or	Location				1 □Yes 2 No
	Mar 1-f st	ţċ	Maryland	Montgomery		Kensingto	on		40 - Citizen of Mhat C	ountry?
:	r 28g	ire	10e. Street and Number			10f. Zip Code		Ì	10g. Citizen of What C	ountry?
	h wit	Funeral Director	3800 Lawrence			2089			USA 14. Race - Am	erican Indian
	deat	ner	11. Marital Status	12. Was Deceden Armed Forces		 Was Decedent of H If Yes, specify Cub 	lispanic Ongin? an, Mexican, Pu	(Specify Yes of No- erto Rican, etc.)	Black, Whi	
9	or Ite		Never Married 2 Marrie	If Yes, Give		1 ☐ Yes 2√☐ No	Specify:		Specify: Wh	nite
21215-0036	within 72 hours after death with the Maryland ene. Ithan "natural" or items 23a or 28a-f show he Medical Examiner must be notified at	Completed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates	16a De	cedent's Usual Occup	pation	1	16b. Kind of Business	s/Industry
,	72 h "nati	lete	15. Decedent's (Specify only highest	grade completed)	(G	ive kind of work done e. DO NOT use retire	during most of w d)	vorking		
12	vithin the. than	립	Elementary/Secondary (0-12) 12	College (1-40)		anitor			Healthcar	re
2	iled v Hygie ther t	ပိ	17. Father's Name (First, Middle, L	ast)			18. Mother's N	lame (First, Middle,	Maiden Surname)	
anc	ntal hed	Be c	Unknown Schaal				Unk	nown Rew	ner	<u>.</u>
Maryland	should be filed within and Mental Hygiene. s marked other than "i sumatic event, the Mec	မ	in the state of Deletionship	p (Type. Print)	19b. M	ailing Address (Street	and Number or	Rural Route Numb	er, City or Town, State,	Zip Code)
Ma	d 2 sho th and 7 Is mo traum:		Laurian P. Fasa	no/ Social	Worker 1	1600 Nebe	1 Street	, Rockvi	11e, MD 208	352
کو	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or Items 23a or 28a-f show Important: If item 27 is marked other than "natural" or Items 20a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	1	20a. Method of Disposition		Jook Diese of Di	eposition (Name of		Date.	20c. Location - City of	or Town, State
ē	nt of nt of t: If it		_1 Rurial 2 MCremation 4 Donation 5 Dother (Sp	3 XRemoval from State	 Metropolit 	crematory or other pla an Cremetory Tashington	Cemete		Alexandria,	Maryland
Baltimore,	urtme urtan injun		21. Signature of Funeral Service L					ing Funer	al Home In	c.
Ba	Depar Impor any Ir		of ours	220		Francis 500 Univ	orsity I	Blvd. W.	Silver Spr	ing, MD 20901
12	SECTION .		one Bottl Inter the disease or	complications that all s	ed the death. Do not	enter the mode of dy	ing, such as card	diac or respiratory a	arrest,	Interval Between
			Immediate Cause (Final	only one cause on each	ine.					Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Severe	Sepsis as a consequence of)					
	Examiner			550						
9		ē	Sequentially list conditions, if any, leading to immediate	b. I neum Due to (or	as a consequence of)					
	uted I ansit	를	Cause (Disease or injury that initiated events	Fungen	iia					1
Ć,	Attending Physician: The law requires that the death certificate be executed reath. sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the bunal-transit	Examiner	resulting in death) Last	Due to (or	as a consequence of)	:				
760,	e be sicia e bur	ca		d						
.89	ificat g phy as th									
Вох	ndin use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	me pf pregnancy n 2 □ Fetal death	3 □Ectopic pregnan	су		23d. Date of Month	delivery Day Year
œ.	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No		t at time of death	5 ☐ Other (specify)				
0	that the di ed by the detached	Completed by Physician/Med	9 Unknown				ium in Dort I	23e Did	tobacco use contribute	e to the cause of death?
<u> </u>	s tha ined l e det	y P	Part II. Other significant condition		h but not resulting in t	ne underlying cause g	liven in Part i.			Probably 4 ☐Unknown
- P	w requires that been signed be should be det	ed t	coronary Arter	y Disease				- 1		
S	s bee	olet						24a. Wa	opsy prior	autopsy findings available to completion of cause of
æ	The la	E						per 1∐ Yes	formed? death	res 2□No
ta	an: tiffica tor, p	BeC	25. Was case referred to medical					Death (Check only		
>	ysici is cer direc	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:					sidence 6 Other (S	Specify)
Division or Vital Records, P.	g Ph er th		27. Manner of Death	28a. Date of (Month,	Injury 28b. Ti Day Year) Inj	ury W			e how injury occurred	
<u>.</u> 0	ndin tth. r.: Aff	atio	1 Natural 5 Pendin investig	gation			☐ Yes 2 ☐ No		(Street and Number o	- Rum I Pouto Number
<u>×</u>	Afte or des octo by th	ific	3 Suicide 6 Could determ	not be lined 28e. Place of building	f injury - At home, farr I, etc. <i>(Specify)</i>	n, street, factory, offic	e	28f. Location City or T	own, State)	naiai nobie ivanibei,
Ö	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:						elega and direkt th	no cause(s) and marro	or as stated
	ospli hour uners ly fills		29a. Certifier X Certifyli (Check only 2 Medical	Examiner: On the bas	is of examination and	death occurred at the /or investigation, in m	time, date and j y opinion, death	occurred at the tim	ne cause(s) and manne ne, date and place, and	due to the cause(s)
	he H in 24 he Fi	Medical	one)	and manne	r stated.		ense number		29d. Date signed (M	
	To t To t	Σ	29b. Signature and title of certific	MATRIM	VMD.	250. 200	D63579			ary 15, 2008
	1			10000	0					
	•		30 Name and address of person Maria J. Tayac	who completed cause	of death (Item 23a) (O Forest (Type, Print) Flen Road,	Silver	Spring,	MD 20910	
		tate	31. Date filed (Month, Day, Year,	2008	giotiai o oignaturo	Sperter				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician January 20, 2008 11:30 PM Isabelle Turner /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 824 North Shore Drive Glen Burnie If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Ye May 10, 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Ĩ915 92 101-07-0406 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 ☐ Yes 2 ☐ No Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 21060 USA 824 North Shore Drive Funeral death v r than "natural", or items the Medical Examiner me 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after anent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or item ury or other traumatic event, the Medical 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Antique Dealer Antiques 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mollie Hoffinger David Turner ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 824 North Shore Drive Glen Burnie, MD 21060 Ellen M. Areman/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important; If ite any injury or of once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory | 01/23/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa are of Funeral Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ne disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a nonsequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 👿 No Day 4□Pregnant at time of death 9□Unknown 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part I). Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. ģ 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performe 2**X** No To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day filled in by the funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 ☐ Pending investigation 1 🗌 Yes 2 □ No 2 Accident Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only

State Registrar 29b. Signature and title of certifier

Elvin

31. Date filed (Mon.

M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

J021

egistrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

January 22, 2008

Ritchie Hury Fute 134 Pasadera MDanz

			For State	State of Marylan	-				0000	00100
		-	1 State Registrar AMFND#10a,b,C, 1. Decedent's Name (First, Middle, Las		,Macoco	tineate or i	Death	2. Date of Dea		3. Time of Death
	Physici /Medi		Earl	Thweatt				Month Jan	Day Year 16, 200	8 8:00P M
Y	Examir		4a. Facility Name (If not institution, give St. Thomas Mor	e Nursing Ho	ome	4b. City, Town, or Hyatts	r Location of Deat		4c. County of Dea Prince	"George's
	Funeral		Social Security Number 6. S	ex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day	, Year) Ci	thplace (State or Foreign ountry)
	Director		Usual Residence of Decedent	¥ ^{M 2□ F} 89	115.			Dec.20	,1918 Vi	ginia
	ryland how		10a. State 10b. County	10c. Cit	ty, Town or Lo	cation hington	DC			10d. Inside City Limits 1X Yes 2 □ No
	he Ma 28a-f s otified	ecto	D.C. Nor.	ıe	Was	10f. Zip Code			10g. Citizen of What C	<u> </u>
	3a or	Funeral Director	2246 Bunkerhill	Rd. N.E.		2001	18		United St	
	tems 2	uner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	. 14. Race - Ame Black, Whi	
36	urs afte al', or i xamln		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:		Specify: P	lack
21215-0036	72 hou 'natura dical E	Completed by	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	pation during most of wo	rking	16b. Kind of Business	/Industry
121	within ene. than '	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)		f_Emplo			Private	
کار 1	e filed al Hygi other vent, t	Se C	17. Father's Name (First, Middle, Last)		-I		18. Mother's Na Julia		Maiden Surname)	
ylaı	tould by Ments	To Be	Roy Thweatt		10h Maili	ng Addross (Stroot				Zip Code)
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at once.		19a. Informant's Name/Relationship (Corine Thweatt	(Wife)	224	6 Bunk	erhill"	Rd. N.I	er, City or Town, State. E Wash, D	C 20018
Baltimore,	of Hez of Hez of item or othe		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □		cemetery, cre.	osition (Name of matory or other place	ce)	Date 2.3	20c. Location - City of Brentwood	
Ĭ,	t. Pag rtment rtant: I		4 □Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer	v) F_C		oln Cemt 2. Name and Addre				
Bal	Depa Impo any li		21. Signature of Funetar Service Lice	3 your	5	732 GA,	Ave.Wa	ineral	Cremation Service 2001	
			23a. Part1. Enter the disease, or consistency, or heart failure. List only	plications that caused the deat one cause on each line.	th. Do not en	ter the mode of dyir	ng, such as cardia	ac or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a ALTENIOSC	CCACT					Silot and Boat
	Examiner			Due to (or as a conseq	quence or):					
	sit s	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):					
an.	execute and al-trans	Examiner	that initiated events resulting in death) Last	cDue to (or as a conseq	quence of):					
68760,	ficate be executed physician and is the burial-transit	edical E		ed						
~	sertifica ding ph se as tl		IF FEMALE:	23c. If yes, outcome pf pregn	ancv				23d. Date of de	livery
Вох	The law requires that the death certific the has been signed by the attending ploage 2 should be detached for use as it	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3	□Ectopic pre g nanc □ Other <i>(specify)</i> _	у		Month	Day Year
P. O.	e law requires that the de has been signed by the a ge 2 should be detached	hys	9 Unknown	9□Unknown	Jalan In Man		una in Don't	220 Did to	obacco use contribute	to the cause of death?
	signec		Part II. Other significant conditions of		sulung in the u	indenying cause giv	venin Faiti.			Probably 4 Dunknown
Records,	s been should	Completed by	RESPIRATOR 1	BOLLIK				24a. Was	an 24b. Were a	autopsy findings available completion of cause of
æ	The la	Somp						autor perfo 1∐ Yes	ormed? death?	_
or Vital	iclan: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	Hospital:	3-00	at 3E DOA Oth	nor:	eath (Check only o		- 16.1
ō	g Physer this eral dil	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	II 3LI DOA	4 Nursing		dence 6 Other (Sp how injury occurred	өспу)
sion	ending eath. or: Aft	atio	1	1		M 1]Yes 2□No		0	Devil Devile Month
Division	after de Direct	Certification:	4 Homicide determined	28e. Place of injury - At h building, etc. (Speci		reet, factory, office		City or Tov	Street and Number or I vn, State)	nurai noute Numbei,
_	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pa	edical C	(Check only 2 Medical Exar	nysician: To the best of my kno niner: On the basis of examina	owledge, deat ation and/or in	th occurred at the ti	ime, date and place	ce, and due to the curred at the time,	cause(s) and manner a date and place, and di	as stated. ue to the cause(s)
	ithin 2.	Medi	29b. Signature and title of certifier	and manner stated.		29c. Licens			29d. Date signed (Mor	nth, Day, Year)
	F 3F 8			18/100		200.	26024		1-18	-08
	~		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type,	Print)		01	10117	
	CA	ate	31. Date filed (Month, Day, Year)	3 Registrar's Sign	ature	ce wis	11/10/04	NC	2001/	

Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) \mathbf{P} M January 20, 2008 5:45 Anne Francina Tlholakae 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Casey House If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) Republic of South Africa 8. Date of Birth (Month, Day, Feb 18, 5. Social Security Number 7. Age (In yrs. last birthday) ^{Yea} 1963 1 □ M 2 🖺 F None Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Maryland Montgomery Gaithersburg 1 ☐ Yes 21 No 10g. Citizen of What Country?
Republic of 10f. Zip Code 10e. Street and Number 20878 715 Gatestone Street South Africa 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 14 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Embassy of the 15. Decedent's Education (Specify only highest grade completed) Republic of S. Africa Elementary/Secondary (0-12) College (1-4or 5+) First Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Tanta Mere Klaas Tlholakae 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 715 Gatestone Street, Gaithersburg, MD 20878 Dan Mogotsi (Partner) 20c. Location - City or Town, State
Mafikeng, NW Province, 20b. Place of Disposition (Name of cemetery, crematory or other place) February 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State 2008 Montshiwa Cemetery South Africa 4 ☐ Donation 5 Other (Specify) 21. Signature of F ne I ervice Lice 22. Name and Address of Facility DeVol Funeral Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877 (art1. Enter the disc ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thock, it heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme fate cause (Final disease condition resulting in death) Lung Cancer with metastasis to the Brain Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: yes, outcome pf pregnancy
□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth Month Year in the past 12 months? 1 ☐ Yes 2 🙀 No 5 ☐ Other (specify) 4□Pregnant at time of death 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2 No 1 Yes 26. Place of Death (Check onl one 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Injury 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

death certificate be executed and -tran attending physician a I for use as the burial-P.O. Box 68760 signed by the at d be detached for Division or Vital Records, been si s after decreased and included After this Hospital or Attending filled in by

Exami Physician/Medical Certification:

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

o e

"natural", or items 23a

al Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event

Physician

/Medical

Examiner

Director

Funeral

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Completed

with the Maryland

within 72 hours after death

Maryland 21215-0036

Saltimore,

Completed by Be ပ

27. Manner of Death

1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatury

29a, Certifier

nd title of certifier

29c. License number D64615

29d. Date signed (Month, Day, Year) January 21, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gemevieve Wroblewski, M.D., 1355 Piccard Drive, #100, Rockville, MD 20850

State Registrar

Medical

31. Date filed (Month, Day, Year) 22 JAN 2008



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			1 - State Registra AMEND#20bperFi	State of M -11/30/08,BM/			artment of F <i>rtificate of</i>			ental Hy	giene Reg. No.2	008	03124
		11	Decedent's Name (First, Middle, Language)							2. Date of De	eath		3. Time of Death
	Physici: /Medic		Eleanor Leiter V	allieres						Month January	Day 1 7	Year 2008	4:04 ам
	Examin		4a. Facility Name (If not institution, gi	ve street and number)			4b. City, Town, o	r Location	of Death		4c. Cc	ounty of Death	
			Holy Cross H	ospital				er Spr			Montgomery		
	Funeral			Sex 7. Ag 1 ☐ M 2 🖺 F	je (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under Hours	r 24 Hrs. Min.	8. Date of Bit (Month, Da	of Birth h, Day, Year) 9. Birthplace (State or Fo		
	Director		499-16-6413	10 W 20 F	84	Yrs.					t 30, 1923 Missouri		
pue	>		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						I0d. Inside City Limits
Asro	sho	ŏ	Manual and Mantas				C	41	C				1 ☐ Yes 2 ☑ No
the t	28a- notifi	Director	Maryland Montgo 10e. Street and Number	mer y			10f. Zip Code	TIVEL	Spring	,	10n Citizer	of What Cour	ntrv?
with	3a or it be		3118 Gracefield	Pond Ant T	1 2			0904				U.S.A.	,
t sat	ms 2.	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S		Was Decedent of H	lispanic Or	rigin? (Spe	cify Yes or No	o- 14.	Race - Americ	can Indian,
و الله	or Ite		1 ☐ Never Married 2 ☑ Married	Armed Forces?			f Yes, specify Cub			Rican, etc.)		Black, White,	etc.
5-0035 72 hours af	ral", c	ğ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			I∐Yes 2⊠No	Specify	/:		Sp	pecify: W	h i te
ה ה	natu	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)			lent's Usual Occup		st of workin	na	16b. Kind	of Business/In	dustry
7	han " e Me	현	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	OO NOT use retired	d)		3			
V S	her th		17. Father's Name (First, Middle, Las	1		Ac	imissions O			45' A 44'-4-4'-		Administ	ration
and	and Merital Hygiene. Is marked other than "natural", or Items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Be	_	•				18. MOUI		(First, Middle		rname)	
	d Me nark natic	은	Ira Albert Leit 19a. Informant's Name/Relationship			10h Mailin	a Address (Ctrost	and Mount		Fay Col			
Z	th an			, ,,			g Address (Street					, ,	
a ,	Heal em 2 other		Armand I. Valliere 20a. Method of Disposition	s - nusband	20b. P	lace of Dispo	sition (Name of	1		ate		tion - City or To	yland 20904
	t: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		Park	awn	natory or other plac		01/06	10000		•	
SAILIMO Permit, Pages	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice		, 1'a1		iemorial Pa Name and Addre		01/26 lity	/2008	ROCKV	ille, Mar	ryland
ם פֿ	and		1 amanda	Luden	70-	Hi	ines-Rinald	i Fune	eral Ho	me, Inc	ver Spr	ino Mari	yland 20904
Е.			23a. Part1. Enter the disease, or ber shock, or heart failure. List only	/								ing, nai	Approximate
P	nysician		Immediate Cause (Final									1	Interval Between Onset and Death
	Medical		disease or condition resulting in death)	Due to (or as		ortic Ar uence of):	ieurysm						
E	xaminer			Coron	ary Ar	tery Dis	sease						
TO	s.s _e , ,,,	ner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ience of):							
ecute	ind	am	Cause (Disease or injury that initiated events resulting in death) Last	С.									
cate be executed	cian a	dical Examiner	resulting in death) East	Due to (or as	a consequ	ience of):							
cate				d									<u> </u>
The law requires that the death certiff	certificate has been signed by the attending rector, page 2 should be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome	pf pregna	ncy					220	Data of dollar	004
	atter I for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	1 ☐Live birth 4 ☐ Pregnant a	2 Fetal	death 3	Ectopic pregnancy Other (specify)	У			230	I. Date of delive Month	Day Year
) e	y the	hysi	9 ☐ Unknown	9□Unknown									
s that	ned t	by P	Part II. Other significant conditions	contributing to death b	ut not resu	ılting in the ur	nderlying cause giv	en in Part	I.	23e. Did	tobacco use	contribute to the	he cause of death?
cords,	gis ne	ed b								1 🗆	Yes 2⊠1	No 3 ☐ Prot	oably 4 □Unknown
aw re	s bec	Completed								24a. Was	an 2	24b. Were auto	psy findings available
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VILCII Ician:	ctor, I	Be C	25. Was case referred to medical examiner?					26. Plac	e of Death	(Check only			
Physic	this ce al dire	일	1 Yes 2 No	Hospital: 1 🖾 Inpatie	ent 2 🗆 I	ER/Outpatien	t 3□ DOA Oth	er: 4 🗆 N	ursing Hom	ne 5□Res	dence 6	Other (Specif	(y)
	Vitter t		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		28b. Time of Injury	Wor	y at k?	2	8d. Describe	how injury o	ccurred	
Stend tend	tor: / the fi	cati	2 Accident investigation 3 Suicide 6 Could not be	9				Yes 2□					
or A	Direction by	Certification:	4 ☐ Homicide determined	building, et	c. (Specify	me, fami, str	eet, factory, office		2		wn, State)	lumber or Hura	al Route Number,
spital	ours neral filled		29a. Certifier 1 🗵 Certifying P	hysicían: To the best	of my knov	wledge, death	occurred at the tip	me, date a	ind place, a	nd due to the	cause(s) an	nd manner as s	tated
the Hospital or Attending Physician:	within 24 hours after death. To the Funeral Director; After this certificate h. completely filled in by the funeral director, page	Medical	(Check only 2 ☐ Medical Exa	miner: On the basis o and manner st	f examinat	ion and/or in	vestigation, in my o	opinion, de	eath occurre	ed at the time	, date and pl	ace, and due to	o the cause(s)
To th	withir To th comp	ĭ	29b. Signature and title of certifier	10			29c. Licens	e number			29d. Date s	igned (Month,	Day, Year)
	vo		Loveen /	1. thuma	NG,	MD	D	59524			Janua	ry 17, 20	008
	V -		30. Name and address of person who										
			Loveen Joseph Put	humana, M.D.			ield Road,	Silver	Sprin	ng, Mary	land 20	904	
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 2 2			k da	sele!						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4:00 P M 2008 January Iris Gertrude Whitt /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 333 Clifton Avenue Arnold 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Davs Hours Min 86 Director 217-24-9066 Dec 27,1921 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits 28a-f show Examiner must be notified at MD Anne Arundel Arnold Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 333 Clifton Avenue 21012 USA 23a Funeral or items 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: \$ Specify: White 3 ₩ Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Homemaker **Home** 12 and Mental Hygie is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nunny Nicerander Ruth McCoy ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: if item 27 is any injury or other trauonce. Darlene Wagner/ Granddaughter 333 Clifton Avenue Arnold, Maryland 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jan. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory 4 □ Donation 5 □ Other (Specify) 2008 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part!/ Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Kectal (ancer months **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or derlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Hospital or Attending Physician; The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 2 ER/Outpatient 3 DOA After this 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Matural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 50152 & Miller MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Birg. ++ G E Miller MD, 2003 Medical Parkway Snite 100 Annapolis MI) 21401 32. egistrar's Signature 31. Date filed (Month, Day, Year) Gen JAN 1 8 2008 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 10:00 M Faith Wenk 22, January 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 501 Bently Court If Under 1 Year Hagerstown Washington Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) ear If Under 24 Hrs. ays Hours Min. **Funeral** 1 ☐ M 2 🖾 F **Director** 183-28-9931 Aug. 27,1933 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at anone. Director 1 ☐ Yes 2 🛣 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 501 Bently Court Pages 1 and 2 should be filed within 72 hours after death \u00e4nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23s 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Be Completed by Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Cashier Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Harvey J. Pascal Willowmenia Rose Willemberg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lori A. Ayers/Daughter Bently Court, Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Smithsburg Crematory 1/24/2008 Smithsburg, Maryland 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service See 1601 Pennsylvania Avenue, Hagerstown Md 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Recle /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician for use as the buris Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 2 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 Nio Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) မှ 1 Yes To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this or completely filled in by the funeral directors. 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 41667

⊘H-4 State

Registrar

DHMH 17 Rev 1/2001

Nedical Compos Descritown MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Micheel
31. Date filed (Month, Day)

McCorneck

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** 1:25 A M Bonnie B. Wettstein 14, 2008 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🗓 F July 7, 1921 PA Director 86 074-12-0622 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 XYes 2 No Rockville Montgomery Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20852 United States 1801 East Jefferson Street #610 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Once. Black, White, etc. 1 □XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 ☐ Divorced WW II Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u>Bookkeeper</u> Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fannie Cohen Sol Baskin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11608 Deborah Drive Potomac MD 20854 Nadine Wettstein - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 SpBurial 2 Cremation 3 SpRemoval from State 1/16/08 West Palm Beach, FL 4 Donation 5 Dother (Specify) Menorah Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels Inc. 1170 Rockville Pike Rockville MD 20852 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Yal monag monie Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 XNo Day 4□Pregnant at time of death ‡ 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an this certificate has autopsy 1□ Yes 2 X No To the Hospital or AttendIng Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After (Month, Day Year) Injury 1 Natural 2 Accident 5 Pendina 1 ☐ Yes 2 ☐ No ours after death.
neral Director: A
filled in by the fu investigation 3 ☐ Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C 1 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) title of certifier 29b. Signature and

State Registrar 31. Date filed (Month, Day, Year)

22

2008

of person who completed cause of death (Item 23a) (Type, Print)

32 egistrar's Signature

Atul Rohatgi MD 9901 Medical Center Drive Rockville MD 20850

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Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: -avithin 24 hours after death. To the Funeral Director: After this certifica

			performed? death? 1 Yes 2 No 1 Yes 2 No					
25. Was case referred to medical examiner?		26. Place of Death (C	heck only one)					
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 □	DOA Other: 4 Nursing Home	5 Residence 6 Other (Specify)					
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28c. injury at Work? 1 Yes 2 No	. Describe how injury occurred					
3 ☐ Suicide 6 ☐ Could not be determined		ctory, office 28f.	 Location (Street and Number or Rural Route Number, City or Town, State) 					
29a. Certifier (Check only one)	nysician: To the best of my knowledge, death occur miner: On the basis of examination and/or investiga and manner stated.	red at the time, date and place, and tion, in my opinion, death occurred	due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)					
29b. Signature and title of certifier	HOSPITZLIST	29d. Date signed (Month, Day, Year)						

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2008

State Registrar

Medical

31. Date filed (Month, Day, Year)

JAN 25 2008

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 251 E. PATIFICW FRONCISCO A Daviels, Do Hagastown, MD 32. Figistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decement's Name (First, Middle, Last) January 17, 2008 **Physician** 8:25P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Renaissance Gardens @ Riderwood Silver Spring | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Year) | Sept. 14, 1910 7. Age (In yrs. last birthday) 97 Yrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 💢 Pennsylvania 164-54-3109 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show notified at Silver Spring 1 ☐ Yes 2 No Maryland Montgomery death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ral", or items 23a or Examiner must be r 20905 United States 14417 Sturtevant Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or antent of Health and Mental Hygiene. and the Tis marked other than "natural", or iten by or othe traumatic event, the Medical Examiner. 1 ∐ Yes 2 🔀 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles J. Meyers Ara Belle Gray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14417 Sturtevant Road Silver Spring, Maryland 20905 Thomas P. Williams, Jr. -son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State permit. Pages 1
Department of IImportant: If Ite
any injury or ot Alleghany Co. Mem. Park 1/26/2008 Allison Park, PA 4 ☐ Donation 5 ☐ Other (Specify) Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Coronary Artery Disease Sequentially list conditions, if any leading to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed bunal-transi Hypertension Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical as the l attending IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒No 3 ☐ Ectopic pregnancy ō Month Year Day 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Osteoporosis; adult failure to thrive; decubitus ulcer 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has t lirector, page 2 s autopsy performed? 1☐ Yes 2 A No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ۴ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: Injury 5 Pending investigation 1 ∏Yes 2 ∏No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1/2/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 01/18/2007 Rachelle M. alexion 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Silver Sonny Alexion 31. Date filed (Month, Day, Year) State 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 2008Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** a_{M} Mary Anna Yakabe January 19, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Montgomery Silver Spring 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 1 M 2 T Yrs. Director 23, 1936 Washington, 577-48-2935 DC Usual Residence of Decedent of filed within 72 hours after death with the Maryland Ital Hygiene.

1 other than "natural", or items 23a or 28a-f show went, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2√☐ No Director Temple Hills Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20757 P.O. Box 98 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White ۇ ك 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker <u>Own Home</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) id 2 should be fill th and Mental H 27 is marked oth traumatic even Be Angelo Maggi Frances Mary Durso ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun once. Joanne M. Darnell/Sister P.O. Box 98, Temple Hills, MD 20757 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 23. Jan. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2008 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. Spring, MD 20901 500 University Blvd, W., Silver 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** _aHyperkalemia /Medical Due to (or as a consequence of): Examiner bAcute on Chronic Renal Failure Sequentially list conditions, it any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner be executed Septic Shock burial-trar and Due to (or as a consequence of): Box 68760 physician Physician/Medical use as the been signed by the attending proposed should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2☐No 3☐ Probably 4☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

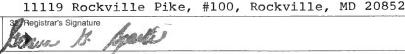
1 ☐ Yes 2 ☐ No 24a. Was an page certificate 2 🖾 No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident al or Attend after death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) 22 JAN

Saima Khawaja,

30. Name and address of person who completed cause of death (Item 2 a) (Туре, Print)

MD



Registrar

D58965

January 19, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For Amend#18,1-23-08, per FHDR, HCHD entificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7:30 P M 20, 2008 Joseph Zitomer January 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 2800 Washington Avenue Chevy Chase Montgomery If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Months Days 1 XM 2 ☐ F Hours Sept 6, 1924 Pennsylvania 577-24-8263 83 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20815 2800 Washington Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1943-54 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 XNo Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 5+ Law/Private Practice Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Tuckoff Mary Tukoff Hymon Zitomer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2800 Washington Avenue Chevy Chase, MD 20815 Mary E. Zitomer/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Chesapeake Crematory: 01/23/08 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Ž MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) KENAZ MILURIS 41. Due to (or as a consequence of) HYPERTEN SIUN Sequentially list conditions Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?)ementu 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 6 bio Hatin 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No

Physician /Medical **Examiner**

Physician

Examiner

Funeral

Director

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ms 23a or 7

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If Item 27 I

Department of Important; If It any Injury or o

Pages 1 and 2 should be filed within 72 hours after death with

Saltimore, Maryland 21215-0036

Director MD

Funeral

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Completed

Be

2

/Medical

Physician/Medical Examiner Completed by Be

25. Was case referred to medical examiner?

5 Pending

investigation

1 ☐ Yes 2 XNo

27. Manner of Death

1 XNatural

2 Accident

3 Suicide

use as the burial-tran physician attending p sate has been signed by the a page 2 should be detached funeral director, After this filled in by

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

State

Hospital or Attending Physician: Certification: To within 24 hours after death.

To the Funeral Director / 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check one) the and title of certifier 29c. License number 29b Signatur DEONSO MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital: 1 ☐ Inpatient

28a. Date of Injury (Month, Day Year)

29d. Date signed (Month, Day, Year) January 22**,** 2008

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 X Residence 6 Other (Specify)

28d. Describe how injury occurred

Rugges Mn 1400 Chery Chare WISCUNSIN 31. Date filed (Month, Pay 2008

2 ER/Outpatient 3 DOA

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28b. Time of

Injury

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene O. O. O.

		-	1 - For State O	iviaryiariu		rtificate of l		- '	Reg. No.	8 03132
,	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Year	3. Time of Death
	/Medic	al	Susan Zorr 4a. Facility Name (If not institution, give street and num	nhor)		4h City Town or	Location of Death	Januar	y 18 200 4c. County of Dea	
F	Examin	er	Manor Care - Potomac	1001)		Potor			Monto	
	Funeral		Social Security Number	7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h 9. Bi	rthplace (State or Foreign Country)
R	Director		171-05-9872 1□M 2対F	94	Yrs.	Wortins Days	Hours With.		1, 1913	PA
	fand ow It		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	ocation				10d. Inside City Limits
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	or 28s	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?
	ath wi	ral	10714 Potomac Tennis Lan				20854		United St	
	iter de	Funeral	Armed Fo		5. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Arr Black, Wh	
920	urs af	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, Giv Year or Divorced Year or Div	e Ac ates:		1 ☐ Yes 2X No	Specify:		Specify:	White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show with the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)		16a. Dece (Give	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of work	king	16b. Kind of Busines	s/Industry
121	within ene. than '	du	Elementary/Secondary (0-12) College (1	-4or 5+)			1) -		O II	
d 2	filed Hygie other ent, th		O 17. Father's Name (First, Middle, Last)	<u> </u>	I.	Iomemaker 	18. Mother's Nam	ne (First, Middle,	Own Home Maiden Surname)	
Maryland	2 should be filled v n and Mental Hygie 'Is marked other t raumatic event, th	To Be	John Shurin				Anna	Unknow	n	
lary	2 sholl and his ma		19a. Informant's Name/Relationship (Type. Print)			-			er, City or Town, State,	
	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene if them 27 is marked other than "natural", or items 23a or 28a-f show then traumatic event, the Medical Examiner must be notified at		William K. Zorr - son	20h Pl	}			Date	burg, MD 2	
nor			20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from			osition (Name of matory or other place eart Cem.	Jaņı	uarv	20c. Location - City of	
altimore,	그두약곡		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee	Dac		2. Name and Addre		, 2008	Whitehall	, PA
ä	Depar Impor any ir		TRACJA-Stew			eVol Fune	eral Home Gaither	, 10 Ea	st Deer Pa MD 20877	rk Drive
r			23a. Part1. Enter the disease, or complications that of shock, or heart failure. List only one cause on e	aused the death. ach line.	. Do not en	ter the mode of dyir	ig, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
0.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Pneun						Oliosi dila Doddi
	Examiner			or as a conseque	ence of):					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	or as a conseque	ence of):					
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Вох	leath certifi attending I for use as	M/ue	230. Was decedent pregnant	come pf pregnar	ncy death 3	□Ectopic pregnancy	v		23d. Date of d	,
.O. E	ne dea the att	Physician/N		ant at time of de		Other (specify)	,		Month	Day Year
Δ.	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use		Part II. Other significant conditions contributing to di	eath but not resul	Iting in the u	underlying cause giv	en in Part I.	23e. Did t	obacco use contribute	to the cause of death?
or Vital Records,	quires n sign uld be	Completed by	Dementia					10	Yes 2 No 3 □	Probably 4 X Unknown
000	e law requir has been si je 2 should l	plete						24a. Was	an 24b. Were	autopsy findings available o completion of cause of
Ä		Com						perfo	ormed? death	es 2 No
Vita	iclan: Sertific ector,	Be	25. Was case referred to medical examiner? Hospital:			Otto	26. Place of Dea	th (Check only o	one)	
o	Phys r this ral dir	.T	1 ☐ Yes 2 ☑ No 1 ☐ 28a. Date	Inpatient 2 E	28b. Time of		400 Ivui 3ii 19 1 i		dence 6 Other (S)	pecify)
on	nding th. r: Afte e fune	atlon	1 X Natural 5 ☐ Pending (Mon 2 ☐ Accident investigation	th, Day Year)	Injury	of 28c. Injur Wor M 1 🗆	rk? Yes 2∐No		,	
Division	r Atte	Certification:	3 Suicide 6 Could not be determined 28e. Place build	of injury - At hor ing, etc. (Specify	me, farm, st	treet, factory, office		28f. Location (City or To	Street and Number or wn, State)	Rural Route Number,
	oltal o urs aft eral DI		W 0							
	24 hou	Medical	29a. Certifier 1X CertifyIng Physician: To the (Check only one) 2 Medical Examiner: On the band man							
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Mo	
	1		· W			D005	54566		January	21, 2008
	>		30. Name and address of person who completed cause							
			Sunitha Bhogavilli , M. 31. Date filed (Month, Day, Year) 3375	D., 9801 Registrar's Signat		gia Aveni	ue, Suite	117, S	ilver Spri	ng, MD 20902
	Sta Regist		JAN 2 2 2008	La Signal		. A				

DHMH 17 Rev 1/2001

Physician
/Medical
Examiner

Fur Dire permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Phys /Me Exam

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been sinned by the attending about any Division or Vital Records, P.O. Box 68760,

	•	For State Registrar		Otato ot III	,	Cer	tificate d	of Death		Re	g. No. 2	800	03133
ysicia	ın	1. Decedent's Name (F	irst, Middle, Las ZHOU							2. Date of Deat Month Jan . 1	^h б, ^{Day} 20	0 Xear	3. Time of Death 8:40A M
Medic amin		4a. Facility Name (If no	t institution, give	street and number)				n, or Location	of Death		4c. Count	ty of Death	
oral		Shady Gr			HOSP je (In yrs. la		If Under 1 Y			8. Date of Birth		tgome 9. Birthp	place (State or Foreign
eral		578-11-2	OOT	MM 2□F	81	Yrs.	Months Da	ys Hours	Min.	8. Date of Birth (Month, Day, Feb. 15	,1926	Ch.	ina
te		Usual Residence of De 10a. State 10	b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
otified	Director	MD	Montgo	mery		Gait	1ersbu			1	0g. Citizen of	What Cou	1 ☐X7es 2 ☐ No
st be n		17714		r Dr				877			•	S.A.	
any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 ☐		12. Was Decedent Armed Forces 1 ☐ Yes 2☐ If Yes, Give Year or Dates:)		Vas Decedent f Yes, specify 1 ☐ Yes 2 🔀			cify Yes or No- Rican, etc.)	BI	ace - Americack, White,	
dical E	eted	15 (Specify	i. Decedent's Ed only highest gra	ducation ade completed)		16a. Deced	dent's Usual O	ccupation one during mos stired)	st of workin	99	16b. Kind of	Business/In	dustry
the Me	Completed	Elementary/Seconda	ary (0-12)	College (1-4or	5+)	Che		urea			Hote	1/ M	otel
event,	Be C	17. Father's Name (Fire	st, Middle, Last,)				18. Moth		(First, Middle, I	Maiden Surna	ame)	
matic	မှ	Zhiche 19a, Informant's Name				19b. Mailir	ng Address (St	reet and Numb		known I Route Numbei	, City or Tow	n, State, Zij	o Code)
er trau		Wei Yi Z		**									MD 20877
or oth			Cremation 3 ☐	Removal from State	CE	emetery, crei	sition (Name on matory or other	place)			20c. Location	,	
Injury e.		4 Donation 5 21. Signatur of Funer			Ga	te 01	F Heav 2. Name and A	en :	1/22, ^{ity} Sno	/2008 owden	Silve Funer	r Sp al H	ring, MD ome, PA
an o	(1)	Test	get	Ause	uth	AL:	246 N.	Wash:	ingto	on St_	Rockv	ille	, MD20850
cian		23a. Part1. Enter the shock, or heart for Immediate Cause (Fin disease or condition		plications that cause one cause on each		Do not ent	er the mode o	dying, such as	s cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
dical iner		resulting in death)	(Due to (or as		ence of):						- 1	
#	ner	Sequentially list condit if any, leading to imme cause. Enter Underly	tions, ediate	Due to (or as		ence of):							.,.
as the burial-transit	Examiner	Cause (Disease or injuthat initiated events resulting in death) Las	ary	c Due to (or a	s a consequ	ence of):		-					
y stolia	ledical E			_ d									
		IF FEMALE:	- 1	23c. If ves. outcom	e of pregna	ncv					234 [Date of deliv	Verv
be detached for use	Physician/	23b. Was decedent pr in the past 12 mo 1 ☐ Yes 2 ☐ N 9 ☐ Unknown	onths?	1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 🗆 Fetal	death 3	□Ectopic pregi □ Other (speci					Month	Day Year
uld be deta	5	Part II. Other significa	ant conditions	contributing to death	but not resu	ilting in the u	nderlying caus	e given in Part	l.	23e. Did to			the cause of death?
ge 2 should	Completed									24a. Was a autop perfor	sy	b. Were au prior to c death? 1 Yes	topsy findings available ompletion of cause of
ctor, pa	Be Co	25. Was case referred examiner?	to medical						e of Death	1 Yes ∩ Check onlor		1 163	2 110
al dire	မ	1 ☐ Yes 2 ☐XNo	_	Hospital: 1 Tripal 28a. Date of In		ER/Outpatie	nt 3 DOA	L		me 5 ☐ Resid			city)
by the funeral director, page	ation		5 ☐ Pending investigatio	(Month, E	lay Year)	Injury	М	Injury at Work? 1 Yes 2]No				
ad in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	200. Flace of the	nj ury - At ho etc. <i>(Sp</i> ec <i>if</i>)	me, farm, st	reet, factory, c	ffice		28f. Location (S City or Tow		mber or Ru	ral Route Number,
completely filled in	edical (29a. Certifier 1 (Check only 2 one)	Certifying P Medical Exa	hysician: To the bes miner: On the basis and manner:	of examina	wledge, dea tion and/or it	eath occurred at the time, date and place, and due to or investigation, in my opinion, death occurred at the t				ue to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)		
omple	Mec	29b. Signature and titl	le of certifier	4			29c. L	icense number	,		29d. Date sig	ned (Montl	n, Day, Year)
_		•	> <	en			D	00 654	78		TANU	ARY	16 2008

State Registrar 31. Date filed (Month, Day, Year) JAN 22 2008

MOHAMMAD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARDEKANI SANAEI Registrar's Signature

9901 MEDICAL CTR DR ROCKVILLE MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008

03134

1-	For State Registra	•
1. D	ecedent's	N

Dest				-	T:		-4	D = = 4b	
Reg. No.									
rygiena	U	V	U	-	,	0			

			Registrar			Cer	tificat	e of L	Death			Reg. No.			
			1. Decedent's Name (First, Middle, Last)							1 2	2. Date of De	ath		3. Time of Death	
	Physicia		Lorain Shirley An	nis							Month Februa	rv 2	, 2008	10:00 A	М
4	/Medio Examin		4a. Facility Name (If not institution, give s	treet and number)			4b. City,	Town, or	Location of I				County of Dea		
	= AGIIIII	٠.	17425 Frederick R	oad			Mt	. Ai	7° 37				Howar	d	
	Funeral		5. Social Security Number 6. Sex		e (In yrs. last	birthday)	If Under	1 Year	If Under 24	4 Hrs.	B. Date of Bir (Month, Da	th		rthplace (State or Forei	ign
	Director		218-32-3500	M 2[XF	79	Yrs.	Months	Days	Hours	Min.	pril l	2.19	28 Ma	ryland	
	ט		Usual Residence of Decedent							-1-					
	ylan		10a. State 10b. County		10c. City, T	own or Lo	cation							10d. Inside City Limi	
	Ma-1-	io	Maryland Howard		Mt	. Ai	rv							1 ☐ Yes 2 🛣 N	10
	n the	Director	10e. Street and Number				10f. Zip	Code				10g. Citi:	zen of What C	ountry?	
	h wil		17425 Frederick Ro	ad			Ì	2177	1			US	A		
	deal	Funeral	11. Marital Status	2. Was Decedent Armed Forces?		13. V	Vas Dece	dent of Hi	spanic Origin	n? (Spec	ify Yes or No)-	14. Race - Am		
9	or its	E	1 Never Married 2 Married	1 ☐ Yes 2 🔀			Yes			ruento n	ican, etc.)		Black, Wh	hite	
<u> </u>	rel',	l by	3 Widowed 4 Divorced	Year or Dates:			105	ZEJ NO	<i>Зреспу:</i>				Specify: W	nicc	
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland and Menall Hygiene. marked other then "naturel", or iteme 23a or 28a-f ehow marked other then "naturel" ar must be notilled at matter event, the Medical Examirar must be notilled at	Completed	15. Decedent's Educ (Specify only highest grade		1	6a. Deced	lent's Usua	al Occupa	ition	of working	a	16b. Ki	nd of Busines	s/Industry	
2	thin the	du	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	OO NOT u	se retired,	uring most o		,				
2	filed w Hygier other th	S		1		Home	maker	:					n Home		
2	be fill ital Hy od oth	Be	17. Father's Name (First, Middle, Last)						18. Mother's	s Name ((First, Middle	, Maiden	Sumame)		
<u>a</u>	Ment Ment arke	ဥ	Harry Granruth						Marie	Bau	mgartr	ier			
œ.	and and series		19a. Informant's Name/Relationship (Type	oe, Print)	1	9b. Mailin	g Address	(Street a	nd Number	or Rural	Route Numb	er, City o	r Town, State.	Zip Code)	
≥	and salth n 27		Eugene Annis	Husband	d 1	7425	Fred	eric	k Roa	d; M	t. Air	у. М	D 2177 cation - City of	1	
e C	of He		20a. Method of Disposition 1 Suburial 2 Cremation 3 R	amoual from State	- com	of Dispo	sition (Nar.	ne of ther place	9) !			20c. Lo	cation - City o	r Town, State	
Ĕ	Pag nent ant: I		4 Donation 5 Other (Specify)	emovarnom State	0ak	Lawn		-		/7/2			-	Maryland	
Baltimore,	permit. Pages 1 and 2 should by Obepartment of Health and Menta Important: If Item 27 is marked eny Injury or other traumatic events.		21. Signature of Furnish Service Licens		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	22	. Name an	d Addres	s of Facility	Ste	rling	Asht	on Sch	wab Witzke MD 21228	
m	89 5 8		CIPA	1)M012	90 1	dnera 630 E	Idmon	me or idson <i>i</i>	Cat Aven	onsvil ue: Ca	.Le, itons	inc. ville.	MD 21228	
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that cause	d the death.	Do not ent	er the mod	e of dying	g, such as ca	ardiac or	respiratory a	rrest,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	000	nges	frie	ho	nt	Fai	lun	_			Onset and Death	
	/Medical		resulting in death)	Due to (or as	a consequen	ce of):	,,,								
	Examiner		WOOTH COME COME												
7		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequen	ce of).									
V	certificate be executed nding physicien and use as the burial-transit	Examiner	Cause (Disease or injury that initiated events												
o`	exe en ar rial-t	EX	resulting in death) Last	Due to (or as	a consequen	ce of):									
68760,	ite be iysici iysici	√Medical										_			
89	tifica ng ph as th	led													_
	h cer endir		230. Was decedent pregnant	3c. If yes, outcome 1 ☐ Live birth			Tetania a						23d. Date of d	elivery	
œ.	The law requires that the death the hes been signed by the etter page 2 should be detached for u	by Physicia	in the past 12 months?	4☐ Pregnant a			Ectopic pr Other (sc						Month	Day Year	
P.O.	it the by th tache	hys	9 🗆 Unknown	9LJ UNKNOWN							1				
ď.	s tha	γ	Part II. Other significant conditions con	tributing to death t	out not resultin	ng in the ur	nderlying c	ause give	n in Part I.		23e. Did	tobacco u	ise contribute	to the cause of death?	
ë	w require been sign should b										10	Yes 2	2 Ho 3□1	Probably 4 Unknow	wn
င္တ	s been 2 should	Completed									24a. Wa		24b. Were	autopsy findings availal	ble
æ	The It	E										omed?	death'	completion of cause of es 2□ No	OT .
Ē	an: tifice or, p	0	25. Was case referred to medical						26 Place o	of Death	1 ☐ Yes (Check only		1016	5 2 NO	
>	Physician: this certifice ral director, p	To B	examiner?	ospital: 1 □ Inpati	ent 2 ER	/Outpatien	it 3□ DC	Othe	NC.				6 ☐Other (St	necity)	
Division of Vital Records,	g Phy er thi		27. Manner of Death	28a. Date of Inju	ıry 28	b. Time of		28c. Injury Work			8d. Describe			Sony	
<u></u>	Aft.	e de	1 ♣ Aatural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Da	iy Year)	Injury	М		c? Yes 2∐No	lo					
<u> S</u>	Attending in death. ector: After by the funer	E C	3 ☐ Suicide 6 ☐ Could not be	28e. Place of In	jury - At home	, farm, str	eet, factor	y, office		2	8f. Location	(Street an	d Number or	Rural Route Number,	
á	efte Direction d in t	Certification:	4 Homicide	building, e	tc. (Specify)						City or 10	wn, State))		
	To the Hospital or Attending Physician: The la within 24 hours effect adaily. Other Funeral Director: Affect his certificate hes completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Phys	ician: To the best	of my knowle	dge, death	occurred	at the tim	ne, date and	l place, ai	nd due to the	cause(s)	and manner	as stated.	
	ne Hc n 24: ne Fu	Medical	(Check only 2 Medical Examinations)	ner: On the basis of and manner si	of examination lated.	and/or in	vestigation	, in my of	oinion, death	n occurre	d at the time	, date and	d place, and d	ue to the cause(s)	
en o	To the To the Comp	ž	29b. Signature and title of certifier				290	. License	number			29d. Da	te signed (Mo	nth, Day, Year)	
			1 Kane	m				03	344	P		2	-4-	0 \$	
	n		30. Name and address of person who co	mpleted cause of	death (Item 23	Ba) (Type.	Print)								
	/1				-		-								
)		Kenneth H. William	Man	1120.5	I. Ro	11170	Dist	A. Cal	i com	m 1.1.	MT	9.0995		
) Sta	ite	Kenneth H. N11113a 31. Date filed (Month, Day, Year)	32. Regist	1120 Tran's Signature	L. Ro	lling 707	, Roa	d; Cal	Louis	ville,	MD	21228		

		1	For State Registrar	State of Maryland		rtificate of L			giene Reg. No. 2008	3 03135
¥,•	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last) Mary Elizabeth	Bryant				2. Date of De Month 02	Day Year 01 200	8 2:19 PM
	Examin Funeral	er	The Acquarius Hos. Social Security Number 6. Sex 10	use	ast birthday) Yrs.	Silver Silver Months Days	Spring If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Sept. 2	y, Year)	
Free	~	J.	Usual Residence of Decedent 10a. State 10b. County DC	1	Town or Lo					10d. Inside City Limits 1 ∰Yes 2 ☐ No
with the Ma	a or 28a-f t be notifie	I Director	10e. Street and Number 6401 14th Street,			10f. Zip Code	2		10g. Citizen of What C	Country?
d 21215-0036 filed within 72 hours after death with the Maryland	riar Hyglene. of other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	y Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.\$ Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🌠 No	ispanic Origin? (Sp an, Mexican, Puerto <i>Sp</i> ec <i>ify</i> :	ecify Yes or No Rican, etc.)	0	
21215-0036 od within 72 hours af	n "natural" Medical Ex	Completed by	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Edur (Specify only highest grade Elementary/Secondary (0-12)	Year or Dates: cation e completed) College (1-4or 5+)	(Give life. i		during most of work d)	ing	16b. Kind of Busines	
Ind 27.	e d c	Be	11 th 17. Father's Name (First, Middle, Last)		Labor	atory As:			NIH , Maiden Surname)	
Maryland	and Mer s marke umatic	ပ္	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State and Street							12
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	k Cree	osition (Name of matory or other place k Cemete	ry 02-0	Date 7-2008	20c. Location - City Washington	n, DC
Balt permit.	Departi Import any inj once		21. Signature of Funeral Service Licens 23a. Panh Enter the disease, or compl	hall	4	217 9th.	St. N.W.	Washin	's Funeral gton, D.C.	20011 Approximate
	ysician Medical		show, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Abdominal Due to (or as a consequence)	Mass					Interval Between Onset and Death
Bi	physician and stransit and transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence). Due to (or as a consequence)						
death cartifi	been signed by the attending phy. should be detached or us as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	Ideath 3	□Ectopic pregnanc	y		23d. Date of Month	delivery Day Year
	n signed by uld be deta	by	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	underlying cause gi	ven in Part I.			e to the cause of death? Probably 4
I Reco	e far has je 2	Completed						per	s an 24b. Were opsy prior death 2 No 1 🗆	
Division or Vital Records, I or Attending Physician: The law requires t	ffer	To Be	27. Manner of Death 1 🖺 Natural 5 🗆 Pending	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time Injury	of 28c. Inju		lome 5□Res	sidence 6 Other (See how injury occurred	Specify)
Division Attent	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	To Z Acodeni								r Rural Route Number,
the Hospit	hin 24 hou the Funer npletely fill	Medical	(Check only 2 Medical Exam	rsician: To the best of my known iner: On the basis of examinating and manner stated.	owledge, dea ation and/or i	investigation, in my	time, date and place opinion, death occi	e, and due to th urred at the time	e cause(s) and manne e, date and place, and 29d. Date signed (M	due to the cause(s)
Jo	To con	2	29b. Signature and title of certifier	MILLI	10	D42			February 5	
	iv		30. Name and address of person who co	9 Rockville P	ike St	e 401 R	ockville,	MD 20	0852	
	St Regist	ate trar	31. Date filed (Month, Day, Year) FEB 0 6 200	32. Registrar's Sign	ature	and I				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** William Balster Jr. February 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Jown, or Location of Death 4c. County of Death Examiner Square oseda more B. Date of Birth (Month, Day, January Year | If Under 2 **Funeral** Months Year) 1929 Baltimore, Maryland 1 M 2 □ F Days Hours 212 26 4689 79 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Bel Air Maryland Harford Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21014 319 Princeton Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XMo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2XX No Specify: White Maryland 21215-003 3 Widowed 4XX Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dry Wall Finisher G & M Drywall Is marked other permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked other any Injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrude Louise Schnaufer George William Balster Sr 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 319 Princeton Lane Bel Air, Maryland 21014 Carol Lee Ackerman Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 □Removal from State February 6 2008 Metro Crematory Inc Baltimore, Maryland 21. Signature of Funeral Service Liver see 22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying bases of injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi P.O. Box 68760, Due to (or as a consequence of): the attending physician the dornary the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9□Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 icate has been sig r, page 2 should b 1 Tes 2₩ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has autopsy performed? Yes 25 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: spltal or Attending Physic hours after death.

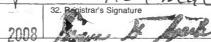
neral Director: After this or y filled in by the funeral dire 1 Yes 2 No 1-Inpatient Medical Certification: To 2 ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral E the Hospital 29a. Certifier 1-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c, License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)



30. Name and address of person who holeted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7:08AM M ANNA RUTH BURRIS FEBRUARY 5, 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE CITY KESWICK MULTI CARE CENTER BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 🛠 💢 F Knoxsville, 414-44-8924 18,1906 Mar. Director 101 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XX No Baltimore County Maryland Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21236 43 Fullerton Heights Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: X Never Married 2 ☐ Married White 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Day Care Center Elementary/Secondary (0-12) 12 yrs. College (1-4or 5+) Care Giver Knoxville, Tn. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Caldwell Charles Burris ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 43 Fullerton Heights Avenue Baltimore, Md. 21236 Bobbie L. Bare (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐Removal from State |Pleasant Hill Cemetery 2-11-2008| Knoxville, Tn. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22LMSSAHMORENTETAL Home 7401 Belair Rd. Baltimore, Md. 21236 asoa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ernen ars: **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to min ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): that the death certificate be executed A STATE OF THE PROPERTY OF THE burial-transit Due to (or as a consequence of) Box 68760. physician Physician/Medical attending IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the 9☐Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by Division or Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? /es 2 No certificate ! Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: after death. After Injury (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FEB

30. Name and address of person who completed cause of

06

2008

DHMH 17 Rev 1/2001

29d. Date signed (Month, Day, Year)

Certificate of Death

DHMH 17 Rev 1/2001

State

Registrar

9125

MA

32. Segistrar's Signature

A.C. CHOHYALTT

FEB 0 6 2008

31. Date filed (Month, Day, Year)

RP,

BELAIR

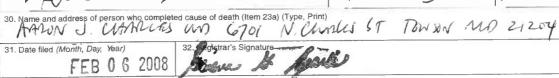
BALTIMORE, MD 21230

Stokely Brooks 212408 0034 Baltimore, Maryland 21215-0036

				State of Maryland / D						, , , , , , , , , , , , , , , , , , ,
		•	For State Registrar		Certifica	te of L	Death		eg. No.	00 00 100
	Physici	an	1. Decedent's Name (First, Middle, Last)	1 7				2. Date of Dea Month	Day-	3. Time of Death 9 2008 12:34 P ^M
	/Medic	al	Stokely Linwood Bro		4b. Cit	y, Town, or	Location of Death	Februar	y 2 4c. County	
	Examir	er	Gilchrist Center	rect are namely		wson			Balt:	imore
W.	Funeral Director		5. Social Security Number 219–18–8729 6. Sex		hday) If Und Month	er 1 Year s Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Novembe)	Year) 17,192	9. Birthplace (State or Foreign Country) 2 Maryland
	pu ,		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location					10d. Inside City Limits
	Maryla f shoried at	jo	Maryland Baltimore	e Tows	son					1 □Yes 2 📉 No
	r 28a-	Director	10e. Street and Number		1	Zip Code			10g. Citizen of W	
	th with side of 23a of 1st be		1305 Denby Rd.			1286				States
36	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ¼Yes 2 □ No If Yes, Give Year or Dates: ₩₩ II	1	cedent of Hi pecify Cuba 2 X No	spanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)	14. Hace Blac Specify	e - American Indian, k, White, etc. " white
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d 2	filed v Hygie other t		17. Father's Name (First, Middle, Last)		- capoa		18. Mother's Nam			
lan	should be nd Mental marked o	o Be	Stokely Linwood Bro	ooks			Mary C	arlton		
Maryland	and s m	[19a. Informant's Name/Relationship (Ty)	' . ' l			and Number or Ru			State, Zip Code)
	1 and 2 Health tem 27 i	l v	Mary Lee Richardson	-,	305 Den			on, MD	21286	City or Town, State
Baltimore,	Pages 1 au nent of Hea int: If Item iry or othe		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ R	lemoval from State	Disposition (A ry, crematory o		- (5 2008		m, Maryland
Ħ	permit. Pag Department Important: I any injury o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License				GardFeb.			
Ba	Dep Imp any		John O. Mitchel	NA.	6	500 Y	s of Facility 11-Wiede ork_Rd.	Baltin	ore, MD	21212
	100		23a art1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the death. Do ne cause on each line.	not enter the m	ode of dyin	ng, such as cardiad	or respiratory as	rest,	Approximate Interval Between Onset and Death
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	/Medical Examiner	П	resulting in death)	Due o (or as a consequenc	of):					1
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause, Disease or injury	Due to (or as a consequence	of):					
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0	be executed ician and burial-transit		resulting in death) Last	Due to (or as a consequence	of):					
8760,	ate be	dical		d						
O. Box 68	res that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	n 3 □Ectopi 5 □ Other	c pregnancy (specify) _	y			ate of delivery onth Day Year
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rds	quires n sign ald be	d by						1 🗆	Yes 2 No	3 ☐ Probably 4 ☐ Unknown
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/ita	clan: ertifica	Be C	25. Was case referred to medical examiner?	Leonited		104		ath (Check only o		
or Vital	ding Physician: The lav n. After this certificate has funeral director, page 2	은	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ ER/O	utpatient 3 Time of	DOA Oth	4 L Nursing r		dence 6 Oti how injury occur	ner (Specify) (WJy) W(
on	ding h. After funer	tion:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury	28c. Inju Wor 1 🗆	rk? Yes 2 □ No		, , ====	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, for building, etc. (Specify)	arm, street, fac	ctory, office		28f. Location (City or To	Street and Num wn, State)	ber or Rural Route Number,
_	Hospital 4 hours a Funeral I tely filled	ical Ce	(Check only 2 Medical Exam	/sician: To the best of my knowledginer: On the basis of examination a	e, death occur nd/or investiga	red at the ti	ime, date and plac opinion, death occ	e, and due to the urred at the time	cause(s) and m , date and place	nanner as stated. , and due to the cause(s)
	o the Printin 24 o the Promplet	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens			29d. Date signe	ed (Month, Day, Year)
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State Registrar

31. Date filed (Month, Day, Year)
FEB 0 6 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Of Marylan		ertificate of L			g. No.200	8 03140
U	Physicia		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Ye	3. Time of Death
	/Medic	al	FRANK J. BAILEY, JR.	_	1		EBRUAR		Ø8 9:28 FM
	Examin	er	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Cer	iter	4b. City, Town, or	Location of Death Towso	n	4c. County of D	ltimore
13-	Funeral Director		5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs 1 M 2 □ F 86	. <i>last birthd</i> a Yrs.	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 9/30/1	Year)	Birthplace (State or Foreign Country) MARYLAND
	and t	1	Usual Residence of Decedent 10a. State 10b. County 10c. C	ity, Town or	Location	<u></u>			10d. Inside City Limits
	Mary i-f sh fied a	ţ	MD BALTIMORE C	OCKEYS	SVILLE				1 □ Yes 2 No
	th the	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What	t Country?
	23a cust b		10881 YORK ROAD		210			USA	American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: WWT		3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2☐No	Spanic Origin? (Spanic Origin? Spanic Origin? Specify:	ecity Yes of No- Rican, etc.)	Black, V	WHITE
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Maryland	be fill ntal H ad oth even	Be	17. Father's Name (First, Middle, Last) FRANK J. BAILEY, SR.				TDEZEVSK		
Z Z	hould id Me mark matic	٩	19a. Informant's Name/Relationship (Type. Print)	19b. Ma	ailing Address (Street				ite, Zip Code)
	nd 2 s lith an 27 is r trau		EILEEN ERSTAD/NIECE	108	CANERBURY	CIRCLE	NICEVILL	E, FL 3	2578
re,	s 1 ar		20a. Method of Disposition 20b.	Place of Dis	sposition (Name of crematory or other place	e) [Date	20c. Location - City	y or Town, State
E	Page nent c int: if		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)/ MC	RELANI) MEMORIAL			HILLENDA	
Baltimore,	permit. Departn Importa any inju		21. Signature of Funeral Sociole Licensee	2	22. Name and Addre 8521 LOCH			N FUNERA SON, MD	L HOME, P.A. 21286
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4	/Medical Examiner		resulting in death) Due to (or as a conso		men make to men.		/ K 1 5" \ E" \		
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on or	nding Ph th. : After th e funeral		27. Manner of eath 1	28b. Tim Inju	ıry Wo	ryat rk? Yes 2∐No	28d. Describe ho	ow injury occurred	
Division	al or Atte s after dea Il Director	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - Ai building, etc. (Spe	home, farm.	, street, factory, office		28f. Location (Si City or Town	reet and Number n, State)	or Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my leading the composition of the best of my leading the best of	nowledge, d	leath occurred at the tor investigation, in my	me, date and place opinion, death occu	, and due to the c rred at the time, c	ause(s) and mann late and place, an	ner as stated. d due to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	1)	29c. Licen	se number	2	9d. Date signed	Month, Day, Year)
	. \		/ with for	V,	D24	034		45/	UD
j	GXI		30. Name and address of person who completed cause of death (I	tem 23a) (Ty	pe, Print)				
1	J		TIMOTHY LOW M. D. 76.71 31. Date filed (Month, Day, Year) 32 registrar's Signature of the strain of	nsl ER	DRIVE	TOWSON.	MARYLA	ND 215	2014
	St: Regist		TED 0.6 2008	A A	(CONCE)				

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ST.		Registrar 1. Decedent's Name (First, Middle, Last)							2. Date of D	Reg. No. 2 3 Jime of Death			
Physici /Medi		DAVI	D	F		BE	-CK		FEB BL	ARY Day	1 2005	1620P	M
Examir				ve street and number)				r Location of Death	1	4c.	County of Deat	h	
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Funeral Director		218-01-9		1 🛣 M 2 🗆 F	90	Yrs.	Months Days	Hours Min.	Dec. 8	ay, Year)	7 Mary	untry) rland	eigir
pui »		Usual Residence of 10a. State	f Decedent 10b. County		10c. City, To	own or Loc	ation					10d. Inside City Lin	nite
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ath wit 23a c lust be		4	502 Pain	ters Mill				.117			U.S.A		
ter des items iner m	Funeral	11. Marital Status	ried 2□ Married	12. Was Decedent Armed Forces? 1 X Yes 2	,	13. V	Vas Decedent of F Yes, specify Cub	lispanic Origin? (S an, Mexican, Puert	pecify Yes or N o Rican, etc.)	0-	 Race - Ame Black, White 		
If it is in the Maryland flied within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23a or 28a-f show ant, the Mickel Examiner must be notified at	þ	3 Widowed		If Yes, Give Year or Dates:	WW I	I 1	☐ Yes 2 No	Specify:			Specify: Whi	.te	
72 hc "natur	Completed	(Spec	15. Decedent's E	ducation ade completed)	1	6a. Deced	ent's Usual Occup kind of work done	oation during most of wor d)	king	16b. Ki	nd of Business/	Industry	
within iene.	dwc	Elementary/Seco	ondary (0-12)	College (1-4or s	5+)		countant			Ac	countir	ıg	
e filed al Hyg other	Be C	17. Father's Name	(First, Middle, Last	t)				18. Mother's Nan	ne (First, Middle	e, Maiden	Surname)		
y car build by Menta arked attc ev	ToE	Elmer Beck Anna E. B							Beall				
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s 1 and f Healf		20a. Method of Disp	position		20b. Place		sition (Name of natory or other pla		Date		cation - City or		
Page:			☐ Cremation 3 ☐ 5 ☐ Other (Speci	Removal from State	Mary:	land	Veterans	Cem.Feb.	.11, 20	08 Ow	ings Mi	lls, Md.	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the M-cical Examiner must be notified at once.		21. Signature of Fu	uneral Service Lice	nsee/	1	22.	. Name and Addre	ess of Facility Funeral	Chanel	. P. A			
		22a Parti Enter t	of Col	successions that caused	d the death [gs Mill	s, Md. 21	
Physician		shock, or hea Immediate Cause (disease or conditio	art failure. List only	one cause on each li	ne.				orrespiratory	arrest,		Approximate Interval Between Onset and Death	1
Physician /Medical		disease or condition resulting in death)	on 🕜		a consequen		CHAP	Y ALV	> F2 1			35 minu	48
Examiner	L	Sequentially list co	enditions,	b. LEFT	ctpo	0170	ENDA	RTERE	CTOM	. Y		2 days	5
ted nsit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nmediate erlying injury		a consequen		EROS					2 days	4
execu	Exar	that initiated events resulting in death) !	5		a consequen) ()				V - years	
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	lical		•	d									
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w requires that been signed k	þ	Part II. Other signif	ficant conditions	contributing to death b	ut not resultin	g in the un	derlying cause giv	en in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown				
v requ	eted								24a. Wa			atopsy findings avail	
The lav te has age 2	Completed								aut	opsy formed?	prior to death?	completion of cause	of
Physician: The land this certificate has sail director, page 2	Be C	25. Was case refer examiner?	red to medical					26. Place of Dea	th (Check only	2 □ No one)	1 ILITES	20110	
Physic this ca	To	1 ☐ Yes 2	1	Hospital: 1 Inpatie			OLI DOX				6 □Other (Spe	cify)	
• 9	tion	1 Natural	5 ☐ Pending investigatio	(Month, Da		b. Time of Injury	28c. Inju Wo M 1 □	ryat rk? Yes 2∐No	28d. Describe	now injur	y occurred		
Atter er deal rector by the	Certification	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not b determined	28e. Place of inj	ury - At home tc. (Specify)	, farm, stre	eet, factory, office			(Street an		ural Route Number,	
ital or urs affer all Direct in lied in													
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifies completely filled in by the funeral director, in	Medical	29a. Certifier (Check only one)	1 Certifying Pl	hysician: To the best miner: On the basis o and manner st	of examination	dge, death and/or inv	occurred at the ti estigation, in my	me, date and place opinion, death occu	e, and due to the arred at the time	e cause(s) e, date and	and manner as place, and due	s stated. e to the cause(s)	
To the within.	Me	29b. Signature and	title Prertifier	and marrier of	arou.		29c. Licens	se number		29d. Dat	e signed (Mont	h, Day, Year)	
			llis	000			RES	-000		FEBR	LUARY	1,2008	
20		30. Name and addr		completed cause of d	leath (Item 23	a) (Type, F	Print)	81 100					757
Sta	te	31. Date filed (Mon	ELLISON oth, Day, Year)	32. Registr	rar's Sanature	KINS	HOSPILL	HL 600 N	MOLITE	>1.	DALIINO	RE MD ZI	4
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orange of the year of the and the mornal try growing.	State of Maryland / Department of Health and Mental Hygien	2 (U	(

			State of Maryland	d / Depa		ealth and	Mental Hygi	attended to the state of	03142		
			Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death		
	Physici /Medic		Willie Burgess, Jr.				January	30 2008	12:05 A ^M		
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of De	ath	4c. County of Death			
			9458 Pinecone Row		Colum			Howard			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. Id. 184_22_9922 103 M 2□ F 79	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H		Year) 9. Birth	place (State or Foreign intry) h Carolina		
ŀ.	Director		184-22-9922 TOLEM 2 79 Usual Residence of Decedent				ray 13,1	926 NOLC	ii Caroriia		
	yland		10a. State 10b. County 10c. City	, Town or Lo	cation				10d. Inside City Limits		
	e Ma	cto	Maryland Howard (olumb:	ia				1 ☐ Yes 2 🛣 No		
	death with the Maryland me 23s or 28s-f show finust be notified at	Directo	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cou	intry?		
	23e	ra	9458 Pinecone Row			045		U.S.A.			
_	Item Item	Funeral	11. Marital Status 1. Never Married 2. Married 1. Never Married 2. Married 1. Never Married 2. Never Married	5. 13. V	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? n, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - Amer Black, White			
2	urs af	by	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 1 Never New 1 Ne	1	I□Yes 20XNo	Specify:		Specify: Bl	ack		
2-003e	within 72 hours after ane. than "natural", or Ite	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa	ation	norkina 10	6b. Kind of Business/I	ndustry		
7	Aithin De. Den	mpie	Elementary/Secondary (0-12) College (1-4or 5+)	Minori	O NOT use retired Lty Busin	ess Dev	elopment F	ederal Avi	ation		
7	be filed within 72 hours after death with the Marylan tal Hygliane. Id eithygliana. Id other than "natural", or Iteme 23a or 28a-f show avent, I'm Madical Examiner must be notilised at	S	17. Father's Name (First, Middle, Last)	OLLICE	31		ame (First, Middle, Mi	V	on		
and	uld be f Aental P rked of	Be c	Willie Burgess, Sr.			Lula G		aroen Sumame)			
>	2 should be and Mental le marked d aumatic ev	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a		_	City or Town, State, Zi	p Code)		
Ma	rt 1		Delores E. Burgess (WIFE)	9458	Pinecone	Row Co	olumbia, M	D 21045			
e e	of Head		20a. Method of Disposition 20b. PI	ace of Dispos	sition (Name of natory or other plac Forest			0c. Location - City or T	own, State		
Ĕ	Pages ment of tant: If it lury or o		1 St Burial 2 □ Cremation 3 □ Removal from State Gar 4 □ Donation 5 □ Other (Specify) Vet	rison erans	Cemetery	2-0	6-2008	wings Mill:	s. MD		
pairimo	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licensee	83 %	Name and Address	neral He	omes, Inc.				
	00 = € a		The state of the s					umbia, MD			
			23a. Part 1 Enfer the disease or complications that caused the death shock, or heart failure. List only one cause on each line.					st,	Approximate Interval Between Onset and Death		
١	Physician /Medical		disease or condition resulting in death)	e m	ultiple	myel	oma				
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	cuted nd transit	Examiner	that initiated events	Due to (or as a consequence of):							
og,	te be executed ysician and he burial-transit		resulting in death) Last Due to (or as a consequ	ence cf);							
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XO	certifica nding phy use as th	/Me	IF FEMALE: 23c. If yes, outcome of pregnant	icy				23d. Date of deliv	/erv		
ň	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Med	in the past 12 months? 1 Ves 2 No. 1 Pregnant at time of de		Ectopic pregnancy Other (specify)		····	Month	Day Year		
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'n	requires that the reen signed by th hould be detache	δ	Part II. Other significent conditions contributing to death but not resu	ting in the un	nderlying cause give	en in Part I.		acco use contribute to			
cords,	pen si	te d	CHF, prostate Cancel	HI	N, ang	s na	1 Tes	s 2 No 3 Pro	bably 4 \textsup Unknown		
•	The law ate has by	Completed by					24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of		
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ō	Phy ar this aral d	7: To	27. Manner of Death 28a. Date of Injury	28b. Time of	1 3L DOA	4 Linursing	28d. Describe how	nce 6 Other (Spec winjury occurred	ify)		
0	ath. r: Afte	atlo	1 ☑ Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury		(? Yes 2 □No					
<u> </u>	r Atte er de: recto by th	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At hot building, etc. (Specify	ne, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rus State)	ral Route Number,		
5	ital o irs aft rai Di										
	To the Hospital or Attending Physician: The law within 24 bours after death. To the Funeral Director: Attar this certificate has completely filled in by the funeral director, page 2 to	edical	29a. Certifier (Check only one) 1 Cartifying Physicien: To the best of my know and manner stated.	rledge, death on and/or inv	n occurred at the time restigation, in my of	e, date and pla pinion, death oc	ce, and due to the cau curred at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)		
	To ti Withii To th comp	W	29b. Signature and title of certifier		29c. License	number		d. Date signed (Month			
			Jan 1	D	D5	0973		January	30,2008		
	10		30. Name and address of person who completed cause of death (flem JA COB) CHERIAN 10910 Little Pai	hixent	Print) Parkwa	4 105	R Colum	bia Md	21044		
	Sta Registr		31. Date filed (Month, Day, Year) Signat FEB 0 6 2008	ure	1 A 1						
DHY	MH 17 Rev 1/20		JOSEPH JOSEPH JA	1							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** P M 4:22 January 28, 2008 R. Bhi de Gopa 1 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bethesda Montgomery Surburban Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1**X**1M 2∏ F India 213-45-6879 99 November 30, 1908 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10b. County r 28a-f show notified at 1 □Yes 200 No Director Maryland Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or must be USA 20817 8004 Lillystone Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, , or items 11. Marital Status Black, White, etc. Examiner 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Specify: Asian þ 3XXWidowed 4 ☐ Divorced Year or Dates: 'natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) than Elementary/Secondary (0-12) Plastic Engineer 12 should be filed war and Mental Hygiei injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Janaki Namjoshi Bhi de Ramachandra ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 Is any Injury or other trau 8004 Lillystone Drive, Bethesda, Maryland 20817 Malini Joglekar- daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Feb.2,2008 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleck Funeral Home, INC. MO 123 Man 7601 Sandy Spring Road, Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart Failure /Medical Due to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Pneumonitis sician and burial-tran Due to (or as a consequence of): ed by the attending physician detached for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical Septicemia 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9☐Unknown 9 ☐ Unknown ate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Atrial Fibrillation Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 ☐ No certificate 1 🗆 Yes 21000 1☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death Check onl on Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 TYes Certification: To this ne Hospital or Attending Ph n 24 hours after death. ne Funeral Director: After th 28d. Describe how injury occurred 27. Many fer of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day Year) Injury 1 Natural 2 ☐ Accident 5 ☐ Pending investigation M 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 🛮 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO020415. January 28, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kamalinee V. Deshpande, MD 8600 Old Georgetown Road, Bethesda, Maryland 20814 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 FEB 06 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month 5:50A M February 2008 Michael Butler /Medical Johnny 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Sinai Hospital of Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1 2 2 4 | 1 2 2 4 | 1 2 4 | 1 2 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 4 | 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1**▼** M 2□ F MD Director 219**-**52**-**8254 58 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Examiner must be notified at 1 Yes 2 No Baltimore Funeral Director MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö U.S.A. 21207 or items 23a 6719 Laurel Drive 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Black þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical al Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Plumbing Company Truck Drive 12th grade na permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked other any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Inez O Connor Eddie Butler Jr. ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7208 Valley Country Ct, Apt A2, Pikesville <u> Shirnique Butler-Daughter</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/8/08 Baltimore Co, Md Woodlawn 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS days /Medical Due to (or as a consequence of): **Examiner** letastatic renal eell carcinoma Sequentially list conditions Due to for as a nonsequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 5 □ Other (specify) __ in the past 12 months? Month Dav Year 4☐Pregnant at time of death 9☐Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Cardiomyopalhy 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an diabetes autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 70 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

1

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Jeena Sandeep, MD

FEB 06

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Redistrar's Signature

Johnny M

Butler,

Registrar DHMH 17 Rev 1/2001 29c. License number

RES OUD

Sinai Hospital of Baltimore, 2401 N. Belvedere Ave, Baltimore Mo

29d. Date signed (Month, Day, Year)

February 3, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 29d per doc 8876 2-6-08 yt State of Maryland Poepartment of Health and Mental Hygiene. 1 - State Amend #1, perMD, g876, 2/6/08 TT Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician GLADYS H. GOONE Gladys H. Boone 9:40P FEB.2,2008 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE CO. 8801 STONERIDGE CIRCLE OWINGS MILLS | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. JAN. 16, 1936 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1□M 2□F 72 213 32 7563 S.C Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County at X□Yes 2□No BALTIMORE OWINGS MILLS MD. the Medical Examiner must be notified Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 21207 USA or Items 23a 8801 Stoneridge Circle Funeral death 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Ite any injury or other traumatic event, the Medical Examine. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 Specify: BLACK þ 3 ∑Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) A T&T Elementary/Secondary (0-12) College (1-4or 5+) LUCENT TECHNOLOGIES 12TH TECHNICIAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ANNIE LAWRENCE MATTHEW HUGGINS, SR. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1419 CEDARCROFT RD. BALTO, MD. 21239 MATTHEW HUGGINS, JR (brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State WOODLAWN CEMETERY FEB. 9,2008 BALTO, MD. 4 pnation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee CALVIN B. SCRUGGS FUNERAL HOME PRESTON ST. BALTO, MD. 213 1412 E. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL INFARCTION Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** CORONARY MOTORY Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Dete of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year Month Day ed by the detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>چ</u> 2 No 3 Probably 4 Unknown 1 ☐ Yes DIABETES MEULTIS Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 2 🗆 No 1 ☐ Yes 26. Place of Death (Check only one) funeral director, Be (25. Was case referred to medical examiner? Other: 4 Nursing Home 5 NResidence 6 Other (Specify) 1 ☐ Yes 2 No 3□ DOA 1 ☐ Inpatient 2 ☐ ER/Outpatient Certification: To this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of (Month, Day Year) Injury 5 Pending investigation To the Hosping.
within 24 hours after deau.
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. CHAPLES ST., STE. 325, BACTMORE 21204 22. Registrar's Signature 31. Date filed (Month, Day, Year) State 06 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 30 **Physician** E. Bray anuary Cleo 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death Examiner saltimore DRY/and General If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 231-34-0047 Yrs. 83 MD 25 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No Baltimore Director MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21201 U.S.A. 1027 Cathedral Street Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: þ Black ₹ Widowed 4 Divorced Completed | 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Domestic Cleaners Elementary/Secondary (0-12) College (1-4or 5+) Dry Cleaning Company 11th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nola Mae Allsberry George Allen ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2756 West Mosher Street, Baltimore, Md 21216 <u>Elva Harris-Sister</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) King Memorial Park 2/5/08 Randallstown, neral Service License 22. Name and Address of Facility
March F/H West 21215 4300 Wabash Ave, Baltimore, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. shoc Immediaty Cause (Final HaSTRO **Physician** disease/ r condition esulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed for use as the burial-tran and Due to (or as a consequence of): attending physician Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) detached במוני nas been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 2 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation r death. 2 Accident after death Director; the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier land General Hospi-30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) FEB 0 6 201

32. Registrar's Signature

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e en	Physici /Medic		ESTHER H. BADE								FEB.	1 20	08	0400p M
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<u>ya</u>		10	STEPHEN C. HUST	red					DOF	РОТН	Y McCo	RMICK		
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Kevin Pully 08-00756

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State of Maryland / Department of Health and Mental Hygiene

2008 03148

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Physicia		gistrar 2 Date of Death 3. Time of Death
/ledical Examin		Lawrence K. Fully Month Day Year 1858 hrs January 27, 2008
	4	a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
`		2211 East Biddle Street Baltimore Social Security Number
Funeral Director	5	Social Security Number 6. Sex // Age (III y III and II
Director	2	18-62-3919 12M 2 F 50 YIS 1 10 1175 1 TO
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or 28a-f show	Director	De. Street and Number 10f. Zip Code 10g. Citizen of What Country?
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hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once	Funeral	12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	0	9a. Informant's Name/Relationship (Type, Print) 4.1.44. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
O g B is ig	유	9a. Informant's Name/Relationship (Type, Print) Methor) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1575 Stonewood Rd, Ruth MD 21239
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and N Important: If item 27 is ninjury or other traumatic.		Da. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
Baltimore, permit. Pages I as Department of Her Important: If ite		Burial 2 Cremation 3 Removal from State crematory or other place)
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Physician	+	3a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and
/Medical		failure. List only one cause on each line. mmediate Cause (Final disease a. Hypertensive atherosclerotic cardiovascular disease
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ox 6 th cer ittendi	iŝi	4 Pregnant at time of death 5 Other (Specify)
. BC he dese y the s	Physician/	1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
P.O.	þ	Cirrhosis of the liver
dS, duires	Completed	24a. Was an 24b. Were autopsy findings available
COFC law re has be	톏	autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Division of Vital Records, P.O. Box 68760, at the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after the death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	ខ្ញុំ	25. Was case referred to medical 26.Place of Death (Check only one)
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Div	Certification:	4 Homicide determined (Specify)
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Division of Vital Records. To the Hospital or Attending Physician: The law requivitin 24 hours after death. To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should	Medical	and manner stated.
	Σ	29b. Signature and title of certifier O.C.M.E. January 28, 2008
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\mathcal{A}		30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
	tate	31. Date filed (Month, Day, Year) 32 Registrar's Signature
Regis		FEB 0 6 2008
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 19a per fft 9877 3-18-08 vt.
State of Maryland / Department of Barth and Mental Hygiene 0 0 8 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) BOSTICR EHRISTING 5 summy 31 204 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BATIMUNG CITY ZOUD SAMONITAN HUSPITAL BALTIMUNG, MD 21239 If Under 1 Year . If Under 24 Hrs. 9. Birthplace (State or Foreign Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Days Hours (Month, Day, Year) 11-15-1945 1□M 2√2F GEORGIA 219-48-9720 62 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 √Yes 2 No BALTIMORE N/A MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21223 USA 6 N. STOCKTON ST. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, GiveX Year or Dates: 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2Ã No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) AIDE **EDUCATION** -12-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MAE BAILEY L.C. CHIVES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) ROSTICK CHUSBAND) STOCKTON ST. BALTIMORE, MARYLAND 21223 PHILLIP 6 N. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 remation 3 □Removal from State METRO CREMATORY 2-5-2008 BALTIMORE, MARYLAND 4 □ Donation Other (Specify) Servin Lensee JONATHAN HIBNER AND Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of ▶1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. F is the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate cross (Final disease or endition resulting in eath) HEMOMUNES STRUKE WITH MIDLINE SITIFF Due to (or as a consequence of): YEMIS HYPORTENSION if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last anothing fet goodfore Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DIAKETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 20 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Physician /Medical Examiner requires that the death certificate be executed Box 68760. P.0. Division or Vital Records, or Attending 24 hours a

Physician

/Medical

Examiner

Funeral

Director

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21215-0036

Maryland

Baltimore.

Registrar

31. Date filed (Month, Day, Year)

FEB 0 6 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D15135

5aucmy 31, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician BERSTOCK** 2008 3:15A M **FEBRUARY** EDWIN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1 EAST UNIVERSITY PARKWAY, N/A APT. 1003 BALTIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country)
IRELAND 6. Sex 1 X M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** 76 08/16/1931 Director 220-36-6209 Usual Residence of Decedent 12 should be filed within 72 hours after death with the Maryland h and Mental Hygene. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at MD 1 X Yes 2 □ No N/A BALTIMORE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 1 EAST UNIVERSITY PARKWAY, APT. 1003 21218 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: WHITE Specify: 3 ☐ Widowed 4 🎇 Divorced of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) PHYSICIAN MEDICINE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evenes. MILLER **BERSTOCK** ABRAHAM ESTHER 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1214 SOUTH CURLEY STREET, BALTIMORE, MD AVI BERSTOCK / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State HILLTOP SERVICE CORP. 02/05/2008 TOWSON, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part / Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, Due to for se a consecuence of Physician/Medical Examiner any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) attending physician the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 3 ☐ Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy perform 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 3 DOA 1 🔲 Inpatient 2 ER/Outpatient Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 2 Accident the 6 ☐ Could not be 3 Suicide To the Hospital or Atter within 24 hours after dea To the Funeral Directo completely filled in by th 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician:

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 0 2008 FEB 6

30. Name and address of person who



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		For State of Maryland / Depart	tment of Health and N <i>ficate of Death</i>	ental Hygiene با Reg. No. د	2008 03151
R D P		1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
Physici /Medic		Noel Blair Hunter Cochrane		February 03,	2008 12:30A. M
Examin		4a. Facility Name (If not institution, give street and number) 4	b. City, Town, or Location of Death	4c. Co	ounty of Death
	Ш	109 Brightwood Club Drive	Lutherville	Ва	ltimore County
Funeral		1 M 2 D E	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
Director		216-14-7537		Dec.25,1919	
and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	tion		10d, Inside City Limits
Maryl f sho ied a'	ō	Maryland Baltimore County Luthervil	le		1 □Yes 2 XNo
the 28a notif	Director	10e. Street and Number	10f. Zip Code	10g. Citize	n of What Country?
3a or		109 Brightwood Club Drive	21093	Unit	ed States
death ms 2 mus	Funeral		s Decedent of Hispanic Origin? (Sp	ecify Yes or No-	. Race - American Indian,
portition of the many family and a second permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The marked other than "natural", or thems 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	1 ☐ Never Married 2 ☐ Married 1 ☒ Yes 2 ☐ No	es, specify Cuban, Mexican, Puerto]Yes 2⊠ No <i>Specify:</i>		Black, White, etc. Pecify: White
tural Es		15. Decedent's Education 16a. Deceder	nt's Usual Occupation	16b. Kind	of Business/Industry
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i with	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 04	Self Employed		
othe vent,	Be C	17. Father's Name (First, Middle, Last)	!	e (First, Middle, Maiden St	urname)
uld b Wenta rrked	은	Laurence Victor Cochrane	Dorothy	Louise Ryan	
2 sho and is ma		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing	Address (Street and Number or Ru	ral Route Number, City or 1	
and and m 27		· 2	outhfield Place	Baltimore,M	**
Jes 1		20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, crema			ation - City or Town, State
. Рас tment tant: jury o		4□Donation 5□Other (Specify) Evans Fune	eral Chapel Feb.(6,2008 Fore	est Hill, Maryland
permit Depart Import any in		21. Signature of Funeral Service Licenses Gur, R. Pea	Name and Address of Facility ICEFUL Alternativ 325 York Road	ves Funeral&C Timonium,Mar	Cremation Ctr.,P.A. Cyland 21093
§.		23a. Party. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on eaer tine.			Approximate Interval Between
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⊋ \	Examiner	Sequentially list conditions, if any, leading to timmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):		,	
and trans	kan	Cause (Disease or Injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			
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ng Ph	T:U	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury	occurred
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To the Hospital or Attending within 24 hours after death of the Funeral Director; After completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death of the basis of examination and/or investigation and manner stated.			
To the withing To the Complex	Ž	29b. Signature and title of certifier	29c. License number		signed (Month, Day, Year)
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1721		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	1569 N C	harlos St	- PP 116m 21204
177) Sta	ate_	30. Name and address of person who completed cause of death (Item 23a) (Type, Pr Dames K. Forterfield 31. Date filed (Month, Day, Year) 32. Registrar's Signature	6569 N.C	harles St	16/08 - PPW600 21204

			For State Registrar	State of Maryla	nd / Dep <i>Ce</i>	ertificate of L	ealth and M Death		giene Reg. No. 20	08	03152
ò	Physic		1. Decedent's Name (First, Middle, La.	HANDLER				2. Date of Dea Month	Day	Year	3. Time of Death 250 ρ м
	/Medi Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of Death	760	4c. County	of Death	
	Funeral	_	5. Social Security Number 6. S	ex 7. Age (In yrs	s. last birthday) If Under 1 Year	MORE If Under 24 Hrs.	8. Date of Birtl	h ,	9. Birthplac	ce (State or Foreign
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	ryland how at		10a. State 10b. County	10c. C	City, Town or I	ocation				10d	d. Inside City Limits
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	n with t	J Dir	10e. Street and Number 817 Gilrubin Court			10f. Zip Code	21212		10g. Citizen of W	hat Country U.S.A	•
	er deat tems 2	Funeral	11. Marital Status	12. Was Decedent Ever in I Armed Forces?	U.S. 13	. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - American k, White, etc	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 □ Yes 2 □ ½ lo	Specify:		Specify:	В	lack
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Karen Ch Baltimore, Maryland	should ind Men ind Men ind marke	은	19a. Informant's Name/Relationship	Chandler	19h Mai	ling Address (Street a	and Number or Bur		ena Chand		Pode)
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Box (death certifica attending ph	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregr 1□Live birth 2□Fet	tal death 3	□Ectopic pregnancy			23d. Date	e of delivery	r lay Year
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VIE.	Physician: this certifica al director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	TER/Outnatie	ent 3 DOA Othe	26. Place of Death		<i>ne)</i> lence 6 □Othe	- (Casaifu)	
<u>n</u>	ding Phy h. After thi funeral o		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury				ow injury occurre		
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	pital o		29a. Certifier 1 Certifying Ph	ysician: To the best of my kn	nowledge des	th occurred at the tim	ne date and place			nnor ac stat	tod
	the Hos nin 24 ht the Fun npletely	Medical	one)	niner: On the basis of examin and manner stated.	nation and/or	nvestigation, in my op	oinion, death occur	red at the time,	date and place, a	and due to th	he cause(s)
	To with	2	29b. Signature and title of certifier	MD		29c. License	number		29d. Date signed	_	
	4		30. Name and address of person who	Thou	m 23a) (Type	Print\		Rge TIM		MA	2/239
· **	Sta	_	31. Date filed (Month, Day, Year)	2. Registrar's Sign	nature	RIVEN B	7 1	1 // / - / 1/0	ISKE !	פיעי	21231
	Registr	ar	FEB 0 6 2008	Marines As	150						

DHMH 17 Rev 1/2001

amend item 8 per fh 876 2-6-08 vt Health and Mental Hygiene () () 8 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 29 **Physician** Cooper Beatrice 2008 January /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 3829 haven 5. Social Security Number 6. Sex If Under 24 Hrs 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 929 9. Birthplace (State or Foreign Funeral Days Months Hours Min. 1 M 2 DF 261-38-589 Director Alabama 25 200 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 le marked other then "naturel", or Items 23a or 28a-f show treumatic event, the Medical Examinat must be notified at WD altimore 1 Tes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 3829 U.S.A Mayeu 21218 death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Menial Hygiene. Inferentant: If item 27 le marked other then "naturel", or Itel may injury or other treumatic event, the Medical Exemires once. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ Ho If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Blac Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) lerica Hospita 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Eddie Carter ANN Willie Palmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cooper 3829 Loch Mayer Blyd Baltimore MI) 21218

e of Disposition (Name of 20c. Location - City or Town, State Husband lhomas H 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ■ Burial 2 □ Cremation 3 □ Removal from State Garrison Forest a/7/08 Baltimore, MI 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses ighn C. Greene Funeral Services Voughn C. Doe no 4905 York Ind Boltimore N

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore MU 21212 Approximate Interval Between Onset and Death

3 W ON THS Immediate Cause (Final Physician metastatic cartenoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the third cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner use as the burial-transit certificate be executed Box 68760-6 and resulting in death) Last Due to (or as a consequence of): Physician/Medicai phys IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy ģ in the past 12 months? Year Month Dav 4☐Pregnant at time of death 5 Other (specify) P.O. the a 9□ Unknown 9 Unknown 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Hypertension 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wasan certificate has autopsy performed? 2 X No 1 🗌 Yes 2 No 1∏ Yes Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) ည 1 ☐ Yes 2 X No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death After t Certification; 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier icai (Check only one) within 2 To the the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D51807 January 31, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, tig W. Fedwood St. Ste 620, MD 31. Date filed (Month, Day, Year) 32. gistrar's Signature Registrar FEB 06 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2008 7:25 A M Clifford February Gordon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Masonic Home Cockeysville Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 1 M 2 ☐ F Director 215-10-1449 97 July 8, 1910 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits T is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 【XNo Director Maryland Baltimore Cockeysville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21030 U.S.A. 300 INternational Drive Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify ۵ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Communication Equipment n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Joseph W. Clifford Elizabeth Taylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any Injury or other traun once. Gordon Clifford 362 Riverside Drive Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 2-6-2008 4 ☐ Donation 5 ☐ Other (Specify) Towson Maryland 21. Si mature di peral ervide Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) be executed attending physician and for use as the burial-tran-Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown been si should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ♣ No 24a, Was an s certificate has blirector, page 2 s 1∐ Yes 2 **2** No director, Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4K Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 2 Accident Medical

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral to

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3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one)	1 Certifying Physi 2 Medical Examin	ician: To the best of my knowledge, death occ er: On the basis of examination and/or investig and manner stated.	urred at the time, date and place lation, in my opinion, death occu	e, and due to thurred at the time	e cause(s) and manner as stated. e, date and place, and due to the cause(s)			
29b. Signature and	title of certifier		29c. License number		29d. Date signed (Month, Day, Year)			
▶ R.1	- Filet	Jim.	D21464		2/4/48			

State Registrar

FEB 06

Robert LIBERTO,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 20 03 04 Minus /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Future Care Canton Hapbon Bultimore MD If Under 1 Year If Under 24 Hrs. 21224 5. Social Security Number 7. Age (In yrs. last birthday) Yrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 6. Sex. 1 M M 2 ☐ F Months Days Hours Min 251-26-909 Director 18/ Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show treumatic event, the Medical Examinar must be notified at Baltimore Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 2734 21213 or items 23e lura U.S. A illed within 72 hours after death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ ¥es 2 ☐ No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes 2 No Specify: ģ Specify: Black 3 Widowed 4 Divorced "neturel", WW TT. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 strown to Department of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mechan 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Manigold (9 la ္ 19a. Informant's Na e/Relationship (7 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2734 Baltotrankie Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other ō ^¹ 4 □ Donation 5 □ Other (Specify) Feb 11,2008 (22. sam and Address of Jacility Carton Color (201 MCCullal 21. Signature of Funeral Service Licensee 9 -ail 5% 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner bvova Sequentially list conditions, Examiner many, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed perten Due to (or as a consequence of): burial-1 attending physician Physician/Medicai the use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Month Year Dav 5 Other (specify) 4 Pregnant at time of death P.O. ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2.2 No certificate 1 ☐ Yes 2 No or Attending Physicien: the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 📉 No Other: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funerel Director: After 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a, Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0055171 02/06/08 30. Name an address of person who completed cause of death (Item 23a) (Type, Print) John 3023 Sebastian tos te 31. Date filed (Month, Day, Year) FEB 0 6 2008 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year James E. Dailey, Sr. 2:04PM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Good Samaritan Hospital **Baltimore** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ N 2 □ F Director 74 215-28-1253 Apr 18, 1933 Maryland Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f show aţ 1 □ ¥es 2 □ No Director **Baltimore** N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō pe 4212 Colborne Road 23a 21229 U.S.A. must. Funeral or items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status the Medical Examiner filed within 72 hours after 2 No 1 ☐ Never Married 2 ☐ Married 1953 1 ☐ Yes 2 ☐ No Specify. þ Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural" 1955 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Aberdeen Proving Ground Hygiene, Army 12 marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Carrie Dailey John Dailey ٩ traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S 4212 Colborne Road Baltimore, Maryland 21229 Jacqueline Coleman Daughter of Health other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 Important: If it any injury or o 1 ☐ **K**urial 2 ☐ Cremation 3 ☐Removal from State **Jepartment** 4 ☐ Donation 5 ☐ Other (Specify) 02/07/08 Crownsville, Md. Crownsville Veterans Cemetery permit, 21. Signature of Funeral Service Lice 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Part 1. Enter the dilease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC /Medical Due to (or as a consequence of) Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) physician the for use as IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) the detached 9□Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 Yes 2 No 3 Probably 4 Whiknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy death? 1 ☐ Yes ↓ perform HISTORY 01 MYGLOM 2 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient Certification: To 2 □ FB/Outpatient 3ELDOA this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of After t 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation (Month, Day Year) 1 Natural 2 ☐ Accident Injury 1 ☐ Yes 2 ☐ No death 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

P.O. Box 68760. Records, or Vital Physician: Hospital or Attending Division after death 24 hours a' the

and

Mary

Baltimore,

JAME

completely 2 8

29a. Certifier

one)

29b. Signature and title of

Medical

State Registrar

DHMH 17 Rev 1/2001

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BROOK, MG

mi

4000

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

SAMARITAN

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

000

MOSPITAL

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Ellsbu 0844-A atricia 28 2008 JUNNERY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 18105 Rolling Meadow Way Montgomery Rockville If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 05/14/1932 Months 1 □ M 2 🔀 F **75** 217-28-8150 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 MYes 2 □ No Montgomery Olney 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20832-18105 Rolling Meadow Way United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Mary Traband Henry Joseph Gerwe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9725 Damascus Rd. Damascus, MD 20872-Barbara M. Miller/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Uniformed Services University 20c. Location - City or Town, State 20a. Method of Disposition Date Jan 29 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 4 ☑ Donation 5 ☐ Other (Specify) Bethesda, MD 21. Signature of Funeral Service Digensee Rapp Funeral & Cremation Services M00382 Stiple Dohmann Silver Spring, Maryland 20910-933 Gist Ave. 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Poncretiz L Gmenth Metartatic Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Cluse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

requires that the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

Hospital or Attending

To the

within 24 hours after death. To the Funeral Director:

Director:

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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23a

"natural", or items 23a dical Examiner must

traumatic event, the Medical

marked other

and 2 should be fill fealth and Mental H m 27 Is marked oth

permit. Pages 1 and 2.
Department of Health at Important: If item 27 Is.
any injury or other traus

72 hours after

within 7 than

Baltimore, Maryland 21215-0036

notified

Director

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Completed

Be

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MD

Examiner burial-trar physician the as attending nse ed by the a detached f signed by peen has certificate l funeral director, this After t

Physician/Medical þ Completed Be Certification: To filled in by the

Medical

State

Registrar

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

5 Pending investigation 6 ☐ Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

MDO60335

#327

29c. License number

1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) January 30, 2008

20832

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Philip

Bannen 18111 31. Date filed (Month, Day, Year) 2008 6

32. Registrar's Signature

and manner stated.

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryla		partment of <i>ertificate o</i>		/lental Hy	giene (Reg. No.	2008	03158
	Physici		1. Decedent's Name (First, Middle, L Wachel Elrod	ast)				2. Date of De Month	Day	Year 2008	3. Time of Death
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, grank Im Squart 5. Social Security Number 6. 212 30 6167	Ho spital	rs. la <i>st birthda</i> Yrs.	Poseo	ar If Under 24 Hrs.		40.00 Ba	ounty of Death The Mov 9. Birthp Cour	
	P .	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimor		City, Town or			500.21	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		10d. Inside City Limits 1 ☐ Yes 2 No
	th with the 23a or 28a Ist be not	Funeral Director	10e. Street and Number 1695 Poles Rd.			10f. Zip Code 2122			_	of What Coul	ntry?
9036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1951		3. Was Decedento If Yes, specify C 1 ☐ Yes 2 🔼 N	of Hispanic Origin? (Spuban, Mexican, Puerto Joe Specify:	pecify Yes or No Rican, etc.)	ł	Black, White,	etc.
bd , Wαchℓ\ Maryland 21215-0036	within 72 h ene. than "natu he Medical	Completed	15. Decedent's I (Specify only highest g	Education rade completed) College (1-4or 5+)	(Gi life	cedent's Usual Occ ive kind of work dor be DO NOT use reti	ne during most of work ired)	king		of Business/In	·
Wach€ and 212	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the MG	To Be Co	17. Father's Name (First, Middle, Las Arthur Elrod	rit)	1	20191000	18. Mother's Nam				31
	1 and 2 should Health and Mer em 27 Is marke other traumatic	Ĕ	19a. Informant's Name/Relationship Joseph D. Elrod	(Type. Print) (Son)	1		eet and Number or Ru.	ral Route Numb			
Ely Baltimore,	Pa mer uny		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			position (Name of rematory or other p 11 Mem. Ga	ardens 2/5	Date /2008		tion - City or To	own, State Maryland
Balt	permit. Depart Imports any inj		21. Signature of Funeral Service Lice	rkruske		22. Name and Ado Bruzdzins 1407 Old	ress of Facility Ski Funera Eastern A	l Home venue E	P.A. ssex,	Maryla	nd 21221
•	Physician /Medical Examiner		23a. Part 1. Enter the disease, or control of the c	a. ASOYA ON De to (or as a conse	Pniun equence of): (NAI		lying, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
68760, *	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical Examiner	Sequentially, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Layynala Due to (or as a conse	canci	PY					
P.O. Box 6	at the death certifi by the attending prached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death	3□Ectopic pregna 5□ Other <i>(specify)</i>			230	d. Date of deliver	ery Day Year
	w requires that been signed b should be deta	þ	Part II. Other significant conditions	contributing to death but not re	esulting in the	underlying cause	given in Part I.		tobacco use Yes 2 ⊠ 1		he cause of death? bably 4 ☐Unknown
Division or Vital Records,		Completed						24a. Was auto perfi 1 Yes	ormed?	24b. Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of 2 ☐ No
Vita	ician certific rector,	o Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:			26. Place of Dea				
ion or	nding Phys tth. r: After this e funeral di	\vdash	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpat 28b. Time Injury	of 28c. In	orker. 4 ☐ Nursing Horigry at vork? ☐ Yes 2 ☐ No	ome 5 ☐ Res 28d. Describe			<u>ý)</u>
Divis	Hospital or Attending 44 hours after death. Funeral Director: After tely filled in by the fune	Certification:	3 Suicide 6 Could not 4 Homicide determined		home, farm, cify)	street, factory, offic	ce	28f. Location (City or To	Street and N wn, State)	lumber or Run	al Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dit completely filled in	Medical	29a. Certifier 1 ☑ Certifying F (Check only one) 1 ☑ Certifying F 2 ☐ Medical Example 1	hysician: To the best of my kaminer: On the basis of examinand manner stated.	nowledge, de nation and/or	ath occurred at the investigation, in m	e time, date and place by opinion, death occu	, and due to the rred at the time	cause(s) ar , date and pl	nd manner as s ace, and due t	tated. o the cause(s)
	To the within 2 To the complete	Ž	29b. Signature and title of certifier	MD			SOOO			signed (Month,	
	841		30. Name and address of person who				Drive Ba	Ihmon	o MD	212:	37
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	forth.	Drive Ba				

			1 - For State Registrar	State of Maryla		artment of H			giene 2008	03159
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death
	/Medi	cal	George Calvin					Feb.	2 2008	3 2:10 a ^M
4	Examir	ner	4a. Facility Name (If not institution, give s			4b. City, Town, or		th	4c. County of Dea	
	Funeral		Longview Nursin 5. Social Security Number 6. Sex	2	rs. last birthday)	Manche If Under 1 Year		8. Date of Birth	Carrol	thplace (State or Foreign
	Director		214-01-6809 ¹ X	M 2□F 91		Months Days	Hours Min	. (Month, Day	8,1916 Ma	ountry)
Pu	100		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Lo					
Aaryla	o ba	ō								10d. Inside City Limits 1 ☐ Yes 2 ☐ No
the	28a-	Director	Maryland Carro 10e. Street and Number	11 1	lanches	10f. Zip Code			10g. Citizen of What C	
with	3a or	0	4310 Miller Sta	tion Rd		2110	2			outiny:
deat	E Pune	Funeral		12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		Specify Yes or No-	U.S.A. 14. Race - Am	
.0036 hours after death with the Maryland	or it	by Fu	1 Never Married 2 Married	1 XYes 2 ☐ No If Yes, Give		1 ☐ Yes 21② No		no Aican, etc.)	Specific	
Maryland 21215-0036 d 2 should be filed within 72 hours af	ture!	q pa	3 XWidowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:		dent's Usual Occupa		-	V	Nhite
d 21215- filed within 72	n n Medic	Completed	(Specify only highest grade	completed)	(Give	kind of work done of DO NOT use retired	during most of wo	orking	16b. Kind of Business	VIndustry
212 d with	giene France	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	Owner	& Oper	ator		Restaur	ant
<u> </u>	and Mental Hygiene. Is marked other then "naturel", or iteme 23a or 28a-f show aumetic event, the Madical Externing count be notified as	Be (17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,		
arylan	Men	٦ ا	Frank Essich					M. Koont		
	alth and 27 is n r traum		19a. Informant's Name/Relationship (Type						r, City or Town, State,	
	E E		Gene Hare - Bro	ner in La 206	. Place of Dispo	sition (Name of			Mancheste 20c. Location - City o	
Pages			1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, crer	natory or other place	1		•	
Baitimore,	Department important: If eny injury or once.		21. Signature of Funeral Service License	e tvr	22	. Name and Addres	s of Facility E	eb. 3,∠(ckhardt	708 Westm Funeral	inster, MD Chapel P.A
n a	8 5 5 8		J. Hend Ella	DS .					ester, MD	_
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the de e cause on each line.	ath. Do not ent	er the mode of dying	g, such as cardia	c or respiratory arr	est,	Approximate Interval Between
	ysician		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	ie to	richt	9			Onset and Death
	Aedical aminer		resulting in death)		equence of):	visett !	30			
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of):	nwenn	MS ON	126 WG		
lufed	dansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	Do	Lan	Co				
, v	an an rial-tr	Еха	resulting in death) Last	Due to (or as a conse	equence of):	-V)				
. BOX 68/6U, Cdeath certificate be executed	physician and the burial-transit	dlcal	d.							
OX D	attending p	/Me	IF FEMALE:	lc. If yes, outcome of preg						
eath o	atten I for u	clan	in the past 12 months?	1 Live birth 2 ☐ Fe 4 Pregnant at time of	tal death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
	by the	hysiclan/Me	1 Yes 2 No 9 Unknown	9□ Unknown		, o.i.o. (speelly)				
Ords, P.O	been signed by the should be detached	by P	Part II. Other significant conditions conf	ributing to death but not re	sulting in the ur	nderlying cause give	en in Part I.	23e. Did tol	pacco use contribute t	o the cause of death?
COrds, w requires t	sen si	ted						1 🗆 Ye	s 2 □ No 3 □ P	robably 4 Unknown
' h >	has b	ompleted						24a. Was a autops	y prior to	utopsy findings available completion of cause of
E The	icate	O						perform 1 ☐ Yes	med? death? 2 No 1 ☐ Yes	
VII.	certif	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 💢 No	ospital:	7	Othe	vr .	ath Check only on		
o A	er this	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of	3 DUA	4 Nursing F	T	ence 6 Other (Special Control of the	ocify)
STOIL Tending	or: Aft	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		:? ∕es 2 ☐ No			
N Att	irecto	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre	eet, factory, office		28f. Location (St City or Town	reet and Number or R	ural Route Number,
D lead	illed ii									
To the Hospital or Attending Physician:	while 24 mous area loads. To the Funarai Director, Alter this certificate has completely filled in by the funeral director, page 2:	edical	29a. Certifier (Chack ani) one) 1 Certifying Physic z Medical Examina	cien: To the best of my kr or. On the basis or examinand manner stated.	nowledge, death lation and/or inv	occurred at the time restigation, in my op	e, date and place inion, death occi	e, and due to the caurred at the time, d	ause(s) and manner a ate and place, and du	s stated. a to the cause(s)
To the	ro the	Σ.	29b. Signature and title of certifier	and marrier states.		29c. License	number	2	9d. Date signed (Mon	h, Day, Year)
,- :			▶ Glawyd	CW W		NS	1705		2-4-0	B
١	a 1	I	30. Name and address of person who con	0 1 0 1	m 23a) (Type, I	Print)	0 1	Cond	٠٠٠٠ ١	ND 21157
	V		M. PANSURLY		Natu	alm D	KI	LIESTAN.	MUSTER	110 2115
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Sigr	Moch	8)				

08-00935 Nolan Edwards

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	2008	03160
State of Maryland / Department of Health and Mental Hygiene		00100
Continue of Dooth		

		1- For State Certificate of Registrar	f Death	Reg. No.
Physic		Decedent's Name (First, Middle,Last)		2. Date of Death 3. Time of Death
l Exan	niner	1101dll Edwards		February 2, 2008
		Facility Name (if not institution, give street and number) Gilchrist Hospice Center	4b. City, Town, or Location of Death Towson	4c. County of Death Baltimore County
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Mir	Foreign Washington
Directo		577-48-3987 1X M 2 F 72 Yr	6.	Nov. 7, 1935 country) D.C.
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loca	tion	10d. Inside City Limits
¥	a .	Arizona Maricolna Scottsda		1 Yes 2 X No
Maryland 28a-f show	ğ	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
with the Maryland is 23a or 28a-f she	Director	7722 East Fledgling Drive	85255	U.S.A.
MSO ath with the N fems 23a or	a		as Decedent of Hispanic Origin? (S	
aath w	Funeral	1 Never Married 2 X Married Armed Forces?	res, specify Cuban, Mexican, Puerto	
ter de	T	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	Yes 2 X No specify:	_{Specify:} White
urs af Itural	g P	or Dates:	nt's Usual Occupation (Give kind of	work done 16b. Kind of Business/Industry
5-0036 led within 72 hours a Hygiene. other than "natural the Medical Feamin	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	nost of working life. DO NOT use ret	·
036 ithin me. r tha	ם	12 Eleva	tor Constructor	Elevator Union -10
15-003 filed within Hygiene. d other the	3	17. Father's Name (First, Middle, East)		e (First, Middle, Maiden Surname)
121 I be fi arked	B			et Mulligan
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other manning event the Medica	2			Rural Route Number, City or Town, State, Zip Code) Drive Scottsdale, AZ 85255
		, ,	sition (Name of cemetery,	Date 20c. Location - City or Town, State
imore, MD 2121 Pages 1 and 2 should be finent of Health and Mental I and I item 27 is marked and marked the transmatic scort		1 Burial 2 Cremation 3 Removal from State crematory or c	ther place)	
Lim Pag ment tant:	5	4 Donation 5 Other Specify: Metro Cr	ematory 2-	6-2008 Catonsville, MD
Baltimore, permit. Pages 1 and Department of Heal Important: If item in inconstructions or other tea		21. Signature of Euneral Service Ligersee M0(05) 22.	Name and Address of Facility $W_{ar{J}}$	itzke Funeral Homes, Inc. Road Columbia, MD 21045
nysicia	_	23a. Part I. Enter the dispase, or complications that caused the death. Do not enter		or respiratory arrest, shock, or heart
Medica		failure. List only one cause on each line. Immediate Cause (Final disease a Amyotrophic lateral sclere	osis	Between Onset and Death
Examine		or condition resulting in death) Due to (or as a consequence of):	7010	
	L	Sequentially list conditions, b.		
	Examiner	If any, leading to immediate Due to (or as a consequence of):		/
	ă a	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
and and				
760, Crate be executed physician and the burial stransit	/Medical	AMENDED #23a,27.perME.g877.3/5	/08 TT	
68760 certificate b nding physical				23d. Date of delivery
Sox 687 Jeath certific e attending J	ciar	past 12 months? 1 Live birth 2 F Pregnant at time of death 5	etal death 3Ectopic pregn other (Specify)	nancy Month Day Year
Box e death c the atten	Physician	1 Yes 2 No 9 Unknown 9 Unknown	Miler (Specify)	
that the de			underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
res th				1 Yes 2 No 3 Probably 4 Unknown
ords, w requir	Completed			24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of
Reco The law	m d			performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
tal Rection: The certificate	S	25. Was case referred to medical	26.Place of Death (Check	
Vital hysician:	0 8	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	nt 3 DOA Other Nurs	ing Home 5 Residence 6 Other:
ision of Vital Records, P.O. Box 68 Attending Physician: The law requires that the death certificatu. redeath. The law requires that the attending recent After this certificate has been sligned by the attending by the firments of increases.	-	27 Manner of Death 28a Date of Injury 28h Time of	Injury 28c. Injury at Work?	28d. Describe how injury occurred
ion tendin eath.	i i	1 X Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	1 Yes 2 No	
Division tal or Attendirs after death.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str	eet, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Divisor Aspital or A	E E	4 Homicide determined (Specify)		or rown, state)
DIVI The Hospital or hin 24 hours after the Funeral Director or house of the funeral Director or house or house of the funeral Director or house or house or house of the funeral Director or house or h	5	29a Certifier		
Di To the Hospital Within 24 hours a To the Funeral I	Medical	one) 2 Medical Examiner: On the basis of examination and/or investig and manner stated.		
	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
2 of our		Panete 4) resthall, MD	O.C.M.E.	February 3, 2008
J. B.		30. Name and address of person who completed cause of death (Item 23a)	11 Donn Street Politimes-	MD 21201
A 1			11 Penn Street, Baltimore,	VID 2 1201
Regi			W.	OCME

			Please	Type or Print in	Black Indelil	ole ink. Ensure	All Copies A	re Legible.	
			For State Ragistrar	State of Maryla		ent of Health and	Mental Hygie	me 0 0 8	03161
			1. Decedent's Name (First, Middle, Las	t)	Certific	ate of Death	Reg. 2. Date of Death		3. Time of Death
	Physici /Medic		Naomi E	Edwar	AS		Month 2	Day Year 29 200	8 6:50A.M
	Examir	er	4a. Facility Name (If not institution, give	Street and number) HOSPITAL	7-	ity, Town, or Location of Dea	th	4c. County of Dea	th
	Funeral Director		707-77-1606	7. Age (In yrs	. last birthday) If Ur Yrs. Mont			1930 K	thplace (State or Foreign puntry)
	nyland how		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Location		1 1		10d. Inside City Limits
	the Ma 28a-fs	ecto	10e, Street and Number		Baltimo		100	Citizen of Miles C	1 Pres 2 No
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland carment of Health and Mental Hyglene. ortant: if Item 27 is marked other than "naturel", or Items 23e or 28e-f show injury or other traumatic event, Tra Madical Exertifiar must be rediffied at high or other traumatic.	Completed by Funeral Director	4905 Gilran	1 Drive		21214		Citizen of What Co	ountry ?
"	fter de	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 ☑ No	If Yes,	scedent of Hispanic Origin? (specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whi	
5-0036	urel', o	d by	Widowed 4 □ Divorced	1 Yes 2 Mo If Yes, Give Year or Dates:		s 2 No Specify:		Specify:	lack
15-	nin 72 h n "natu Medica	plete	15. Decedent's Ed (Specify only highest gra	de completed)	16a. Decedent's t (Give kind of life_DO NO	lsual Occupation work done during most of wo Tuse retired)	orking 16	b. Kind of Business	/Industry
2121	filed with Hygiene other the	Com	Elementary/Secondary (0-12)	2 General College (1-4 or 5+)	D_{r}	iver	T	ranspo	dation
Maryland	should be fill and Mental H s marked oth umatic even	То Ве	17. Father's Name (First, Middle, Last) Theodore R. G	rinter		18. Mother's Na	me (First, Middle, Mai	den Sumambe)	S
Mary	12 sho	1	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing Addr	ess (Street and Number or R	ural Route Number, C	ity or Town, State, .	Zip Code)
	permit. Pages 1 and Department of Health Important: If Item 27 eny Injury or other tr once.	,	James E. Edv 20a. Method of Disposition		Place of Disposition (Varie of	Date 200	c. Location - City or	Town, State
Baltimore	Pages ment of I ant: If Its ury or o		Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	rison Te	rost omeden	6/08 Qu	onas Mi	Us. MD
Balt	permit. Pag Department Important: eny Injury c once.		21. Signature of Funeral Service Licen	See L	Vau	and Ad of Facility	ve Ferrer	uter	de
	- 3		23a. Part1. Enter the disease, or comp shock, or heart failure. List only				c or respiratory arrest,	OMD 2	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	CHRONIC OBS	STACTIVE A	PHLMONARY S	DISEASE		Onset and Death
	/Medical Examiner	0	resulting in death)	Due to (or as a conse	quence of);				
	p H	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as a conse	quence of);				
JA.	executed and al-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):				
68760,	icate be ex physician s the buria	1	(d					
39 X	leath certifica attending pt I for use as t	/Med	IF FEMALE:	23c. If yes, outcome of pregr	nanov				
D. Box	The law requires that the death certificate be ex the has been signed by the attending physician age 2 should be detached for use as the burial	Physician/Medical	in the past 12 months?	1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 □Ectopi	pregnancy (specify)		23d. Date of de Month	Day Year
P.O.	that the died by the detached		9 ☐ Unknown Part II. Other significant conditions co		sulting in the underlyin	g cause given in Part I.	23e. Did tobac	co use contribute t	o the cause of death?
of Vital Records,	w requires been sign should be	Completed by		TENSION			1. Yes	2 □ No 3 □ P	robably 4 ∐Unknown
eco	e law requ has been je 2 shoul	nplet					24a. Was an autopsy	prior to	utopsy findings available completion of cause of
tal F		e Cor	25. Was case referred to medical				performed		2 □ No
ίζ	Si Si	To B	examiner?	Hospital: 1 Inpatient 2	ER/Outpatient 3	Other	ath <i>(Ch</i> ec <i>k only one)</i> Home 5 ☐ Residenc	e 6 ☐Other (Spe	ocify)
o uc	ding h. After fune		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how	injury occurred	
Division	ten feat for: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h	nome, farm, street, fac		28f. Location (Stree City or Town, S		ural Route Number,
Ö	To the Hospital or At within 24 hours after or To the Funeral Director Completely filled in by								
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone)	sician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, death occurr ation and/or investigat	ed at the time, date and plac ion, in my opinion, death occ	e, and due to the caus urred at the time, date	e(s) and manner a and place, and dur	s stated, e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	MT		29c. License number		Date signed (Mont	
•			30. Name and address of person who o	Muleted cause of death (the	m 22a) /Time Print	RES 000		1/29/2	
	4		SABAEVA ELENA	. GCH 560	1 10SH A	PAVEN BLV.	O, BALTI	MORE	MD, 21239
	Sta Registr	7.0	31. Date filed (Month, Day, Year) FEB 0 6 2	32. Registrar's Sign	ature				

Les Foreman 08-00602 UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

NK UNK	State of Maryland / Department 1- For State Certificate	of Death	2008 03162
Physician/	Registrar	2. Date of Dea	
edical Examine	Heo Toreman	Month January 2	
	Facility Name (if not institution, give street and number) Washington Adventist	4b. City, Town, or Location of Death Takoma Park	4c. County of Death Montgomery
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		th (MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		Yrs. Months Days Hours Min. 04/01/	1950 Country) Georgia
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	cation	10d. Inside City Limits
<u> </u>	MD Prince George's Mt. Raini	ier	1 Yes 2 X No
the Maryland a or 28a-f show lifted at once.	10e. Street and Number	10f. Zip Code	0g. Citizen of What Country?
th the M 23a or 2 aotified	3302 Chauncey Place #302	20712	USA
or items 23	1 X Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
safter de rral", or niner mu	1 Yes 2 No 3 Widowed 4 Divorced of Pales:	Yes 2 X No specify:	Specify: Black
hours a matura Exami		dent's Usual Occupation (Give kind of work done most of working life. DO NOT use retired)	16b. Kind of Business/Industry
5-0036 ed within 72 hours tygiene. other than "natu he Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12th Mate	erial Handler	Federal Government
215-0036 be filed within 72 hours after death with the Maryland mal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle,	
	Edward Foreman	Carrie Steele	
MD 21 d 2 should lth and Me In 27 is ma aumatic ev		ling Address (Street and Number or Rural Route Nur 7 9th Street, NW Washing	
4 E E E	20a. Method of Disposition 20b. Place of Disp	position (Name of cemetery, Date	20c. Location - City or Town, State
Pages ent of unt: If	1 X Burial 2 Cremation 3 Removal from State crematory or 4 Donation 5 Other Specify:	Memorial Park 02-04-2008	Landover, MD
Baltimore, permit. Pages I at Department of Hee Important: If ite injury or other tr		2. Name and Address of Facility Marshall	s Funeral Home, Inc.
Physician	23. Part I. Enter the disease, or complications that caused the death. Do not enter	4217 9th Street, NW Wash	
/Medical	failure. List only one cause on each line. Immediate Cause (Final disease a. Asthma	, ,	Between Onset and Death
aminer	or condition resulting in death) Due to (or as a consequence of):		
-e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
ted nsit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated Leventz resulting in death). Let		
ecuted and transit	events resulting in death) Last Due to (or as a consequence or): d.		
Box 68760, death certificate be executed the attending physician and ed for use as the burial - transi nysician/Medical E.	X UNPENDED AMENDED 7, perME, g876, 2/	14/08 TT	
876(ifficate ig physis the b		Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
Sox 6876 leath certificate attending phy for use as the I	past 12 months? 1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5	Other (Specify)	
D. BC trithe dear by the z	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I. 23e. Did t	obacco use contribute to the cause of death?
P (s 2 No 3 Probably 4 V Unknown
rds requ been hould		24a. Was	
tal Reco			ormed? death? 2 No 1 Yes 2 No
tal Fician: certificate tector, p	25. Was case referred to medical examiner?	26.Place of Death (Check only one)	
Physical dir	1 ✓ Yes 2 No Inpatient 2 ✓ ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time	ent 3 Box 4 Harsing from 5	Residence 6 Other:
on of ending Pt ath. or: After he funeral tion: T	1 X Natural 5 Pending (Month, Day, Year)	1 Yes 2 No	
Division tall or Attendir its after death. An Director: A led in by the fu	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s'	treet, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City
Division of Vital to Hospital or Attending Physician: The Hours affected: After this certifeeter, After this certifeeter, filled in by the funeral director, Call Certification: To Be (4 Homicide determined (Specify)	or rown,	
Sa es E Z E	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death ocone) 2 Medical Examiner: On the basis of examination and/or investi	curred at the time, date and place, and due to the cau igation, in my opinion, death occurred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
To the within To the compl	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	Dama mi incardi in D.	O.C.M.E.	January 22, 2008
	30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 1	11 Penn Street, Baltimore, MD 21201	100000000000000000000000000000000000000
State	31. Date filed (Month, Day, Year) 32 Registrar's Signature		
Registra	FEB 0:6 2008	web .	

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 3, **Physician** 2008 5:48 PM Paul David Fotheringham /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 307 Sassafras Road Baltimore Essex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days 1√ M 2□ F 57 214 54 7272 27,1950 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 No Directo Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 307 Sassafras Road 21221 USA s 1 and 2 should be filed within 72 hours after death v f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②XNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Engineering Associate Aero-Space 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mildred Lilly George Samuel Fotheringham ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Fotheringham 307 Sassafras Road Essex Maryland 21221 (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages ' permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Inc. 2/04/2008 Baltimore, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home PA 21. S viture of Fune ensee 1407 Old Eastern Avenue Essex MAryland 21221 23a. Part1 Enter the disease s. ock or heart failure. L complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate ause (Final disease or condition **Physician** Myscardia /Medical resulting in death) Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertains Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the burial-transit the death certificate be executed Exam that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month signed by the at Id be detached fo 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 🗌 Yes No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2 s autopsy performs 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No ည 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 27. Manner of Peath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural
2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation is any arising death. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

15

State Registrar

Douglas

29b. Signature and title of certifier

Michael

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Martin

Baltimore, MD 7602

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #17, perFH,g876, 2/6/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Lynary SUE FRAHM /Medical 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hos BALTIMORE 0 N/A may Lowe If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex Sex 1 M 2 K 7. Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign **Funeral** 73 02715/1934 LITHUANIA Director 219-28-4485 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits BALTIMORE MD BALTIMORE 1 ☐ Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 2331 OLD COURT ROAD, UNIT 503 21208 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) PUBLIC LIASON BALTIMORE CO GOVERNMENT permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othany Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ISAAC MINNIE STEIN Varhaftik ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EUGENE FRAHM / HUSBAND 2331 OLD COURT RD., #503, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State BETH JACOB CONG. 02/05/2008 FINKSBURG, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1180 /Medical t (or as a consequence of) Examiner Sequentially list conditions, if any, the angle immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse juence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 Yes 2 No Division or Vital Records, P.O. 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 s 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3□ DOA 2 ER/Outpatient Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 🔀 Natural 5 Pending Injury death. investigation 1 □ Yes 2 □ No nours after death.

neral Director; / 2 ☐ Accident 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital c within 24 hours af To the Funeral D completely filled i Medical 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature/an 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year

6

32. Régistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Goodman 10 20 PM January 27 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Oeath Examiner Holy Cross Nursing Facility Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 🖼 F Director 81 Yrs 579-32-1530 Usual Residence of Decedent 07/08/1926 Pages 1 and 2 should be filed within 72 hours efter death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "natural", or iteme 23s or 28s-f ahow treumstic event, the Medical Examinar must be notified at Directo 1 ☐ Yes 2 No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20910-United States Completed by Funeral 2201 Colston Dr. #801 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 ☐ Widowed 4 St Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Education al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Assistant Principle 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked of Laura Taylor 2 James W. Pace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 #329 Washington, DC 20024-Phillip R. Goodman/Son 301 G St. SW other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If its eny injury or of once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Jan 29 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Inc.2008 21. Signature of Funeral S 22. Name and Address of Facility M00382 Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Failure 40 Incive resulting in death) /Medical Due to (or as a consequence of): Examiner Alzheimer's Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed ettending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Oate of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 Ko 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No funeral 27. Manner of Death 28a. Oate of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge death concred at the line, date and place, and out to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) چ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00053337 28,2008 January 30. Name and address of person was completed cause and death (Item 23a) (Type, Print) KEISTERSTOWN 25 MAIN ST. 31. Date filed (Month, Day, 32. Registrar's Signature State

Registrar

08-00903 James Joseph Gorman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 03166

				I-For State Certificate	of Death	Reg.	No	
a alt	Phys		ın/	Decedent's Name (First, Middle,Last)		Date of Death Month D	ay Year	3. Time of Death 1332 hrs
ileai	cal Exa	arriir		James Joseph Gorman 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	Month D February 1,	2008 4c. County of Deatl	
				309 North Shore Drive	Swanton	11	Garrett	·
	Fune	ral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hr	s. 8. Date of Birth (MM/DD/YYYY) 9. Bit	rthplace (State or Foreign
	Direct		- 1	170 00 0110	frs. Months Days Hours Min	May 19,		PA PA
	/ any		1	10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
	Aaryland 28a-f show	nce.	5	MD Garrett Swanton				1 Yes 2 No
	Maryl 28a-1	dato	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	intry?
7	h the 3a or	ocifie		327 North Shore Dr.	21561		USA	
100	72 hours after death with the Maryland n "natural", or items 23a or 28a-f she	must be notified at once	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puert		14. Race - Amer White, etc.	rican Indian, Black,
	after	iner	by	AA for Dates: GTTR	Yes 2XX No specify:		Specify: Whi	
	hours	Exam		during	dent's Usual Occupation (Give kind of most of working life. DO NOT use re		6b. Kind of Business	/Industry
9	= 2	dical	plet	Elementary/Secondary (0-12) College (1-4 or 5+)			116 41	
5	d with	e Ne	Completed	12 17. Father's Name (First, Middle, Last)	Pilot 18.Mother's Nam	ne (First, Middle, Ma	US Ai iden Surname)	rways
24245 0026	L 13-003c be filed within ntal Hygiene. rked other tha	c event, the Medical Examin		Matthew Gorman	Margar	et unk		
	ould to Men	ic eve		19a. Informant's Name/Relationship (Type, Print)	ling Address (Street and Number or	Rural Route Number	er, City or Town, Stat	e, Zip Code)
2	d 2 sh Ith an	ınmaı			S. Magnolia St., Moor			
	S J an f Heal	er tra			osition (Name of cemetery, other place)	Date 2	20c. Location - City o	r Town, State
2	Page:	r oth			ion Cemetery Feb	9, 2008	Moon Townshi	p, PA 15108
9	Definition of the CICIO-OCA permit. Pages I and 2 should be filed withit Department of Health and Mental Hygiene. Important: If item 27 is marked other it	jury	Ī	21. Signature of Funeral Service Accessee	Pame and Address of Facility, P	.A.		
		_	_	MO1148	426 Crain Hwy S., G1			Approximate Interval
, t	hysici' Medic'			23a. Pal I. Enter the disease on complications that caused the death. Do not entrailluce. List only one cause on each line.				Between Onset and Death
	tamir			Immediate Cause (Final disease or condition resulting in death) Bue to (or as a consequence of):	g atherosclerotic car	diovascular	disease	Deali
		н		b b to (or do d or roots or r).				
			ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
			ami	(Disease or injury that initiated		. <u>-</u>		
	uted	ansit	Ä	events resulting in death) Last Due to (or as a consequence of): d.				
	e exec	the burial - transit	Medica	X UNPENDED ##50,27,28a-f, perME,g8	76 2/25/08 TT			
76.0	cate be	he bur		IF FEMALE: 23c. If yes, outcome of pregnancy	70, 2/25/00 11		23d. Date of delive	ry
703	ertific ding	se as t	sician/	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic preg	nancy	Month	Day Year
.03 20	e death certifi	for use as	sic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5	Other (Specify)			
	t the d	detached	된	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
	es tha	0 41	P P			1 Yes	2 No 3 Pr	obably 4 🗸 Unknown
Š	Of Vital Recolus, ig Physician: The law requir Mier this certificate has been s	plnot	Completed			24a. Was an		autopsy findings available completion of cause of
Š	e la v	ge 2 st	<u>m</u>			perform	ed? death?	,
ò	n: Th	or, pag		25. Was case referred to medical	26.Place of Death (Chec		No 1	res 2 No
4	ysicia ysicia	direct	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	Othor		esidence 6 🗸 Oth	er: Scene
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2	tendir eath.		tio	Natural 5 Pending Fpd 2/1/2008 Fpd 1	:00 pm 1 Yes 2 X No	subject exp	posed to col	d environment
	or Att	in by	ertification:	2X Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s		28f. Location (Str or Town, Sta		Rural Route Number, City
Ë	DIVISION OF VICE RECORDS, F.O. BOX 60/00, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Division: After this certificate has been signed by the attending physician and	filled	Cert	4 Homicide determined (Specify) house			Shore Dr. S	wanton, MD
	To the Hospital or Attend within 24 hours after death To the Funeral Director:	completely filled in by the		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death or	courred at the time, date and place, a	nd due to the cause	(s) and manner as sta	ated.
	To the within 2 To the	comp	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigand manner stated.				
			Σ	29b. Signature and title of certifier	29c. License number		29d. Date signed (M	
Ü	7			Genezz :	O.C.M.E.		February 2, 200	<i></i>
				30. Name and address of person who completed cause of death (Item 23a)	n Street, Baltimore, MD 212	01		
ρ	ind				Sueet, pailimore, MD 212		 -	
		St	al (e	31. Date filed (Month, Day, Year) \$2. Registrar's Signature	APM .			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Month Day **Physician** 11:09 PM 1,2008 February /Medical or Location of Death 4c. County of Death Examiner Memoria Himore st birthday Birthplace (State or Foreign Country) **Funeral** Months Hours Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Baltimore 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. the Journeyman ner's Name (First, Middi Mother's Name (First, Middle, Maiden Surname) Be noner Informant's Name/Relationship (T) City or Town, State, Zip Code) Batto, and : If item 27 i 21230 Smith Baltimore, 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, permit, Page Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 21. Sig. a ore of Fundral Service Licens MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hyperkalemia
Due to mras a consequence of): Physician Day /Medical Examiner Renal Sequentially list conditions, it and a large to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last tailure Dai Examiner Drivi for las e consequence offi burial-transit weeks Congestive
Due to (or as a consequence of): Heart Failure The law requires that the death certificate be execu Division or Vital Records, P.O. Box 68760, 4 months Physician/Medical Hypertension the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? Yes 2 1/No certificate 1∐ Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Thipatient Certification: To 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Avatural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No after death 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D. O. AT 2438946 1,2008 Vin tebruary 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Memorial Hospital D.O Union Irung 3 Registrar's Signature 31. Date filed (Month; Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8

			For State Registrar		State	of Marylan	d / Dep <i>Ce</i>	artmen	t of H	ealth a	and M	ental Hy	giene Reg. No	-	8	031	68
		91	Registrar 1. Decedent's Name (First, Middle, Last)							2. Date of Death 3. Time of Death							
- 1	Physici /Medic		Susan Kay Garrett							February 1, 2008 8:45 A M				АМ			
	Examin		4a. Facility Name (I	If not institution,	give street and no	umber)		4b. City,	Town, or	Location	of Death		4c	. County of I	Death		
1	a managan da da managan da managa			er Balti				Tow						Balti			
	Funeral		5. Social Security N 232–76–13		i. Sex 1 ☐ M 2 🛛 F	7. Age (In yrs.		Months Months	Days	If Under Hours	Min.	8. Date of Bi (Month, Date of Bi Aug 1,	rth a <i>v, Y</i> ea <i>r)</i> 1954		Countr	ice (State or i Virgin	-
24	Director		Usual Residence of			5	3		1			Aug 1,	1334	AAG	-55 C	virgin	.1a
	yland now		10a. State	10b. County		10c. Cit	y, Town or L	ocation							10	d. Inside City	Limits
	a-f sh tified	ctor	Maryland	Howar	rd		Colu	mbia								1 ☐ Yes 2	2 ∑ No
	with the Maryland is or 28a-f show t be notified at	Dire	10e. Street and Nu					10f. Zip					10g. Cit	tizen of Wha		y?	
	death w	Funeral Director	6733 Sew	vells Oro			0 40		1045		0 (0	****		U.S		n Indian	
7	er de Item	'n	11. Marital Status	ried 2 🔀 Married	Armed F	cedent Ever in U. forces?	.5. 13.	If Yes, spe	cify Cuba	spanic Or n, Mexica	n, Puerto	cify Yes or No Rican, etc.)	0-		White, e		
್ದ ೫	n 72 hours after death with the Marylan "natural", or Items 23a or 28a-f show adical Examiner must be notified at	by F	3 ☐ Widowed		If Yes, G	2[X No live Dates:		1 ☐ Yes	2X No	Specify:				Specify:	Whit	ce	
∑ S Q 5-0036	2 hou	ted	/Sna	15. Decedent's	Education	1	16a. Dece	edent's Usu e kind of wo	al Occupa	ation	nt of worki		16b. K	and of Busin	ess/Indu	ıstry	
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nett,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental hygiene. Important: If Item 27 Is marked other than "natur any injury or other traumatic event, the Medical once.	Be	17. Father's Name	r. Riggs	ast)					_		(First, Middle Scott		i Surname)			
七岁	hould d Me mark matic	은	19a. Informant's N		(Type Print)		19b Mail	ing Address	(Street a			I Route Numi		or Town. Sta	ate. Zin (Code)	
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e e	of Health of Health if Item 27 Is		20a. Method of Dis	position		20b. F	Place of Disp cemetery, cre					ate		ocation - Cit			
Gar.	Page nent o nt: If			☐Cremation 3 5☐Other (Spe		i State	COOF C				2-8-2	2008	st.	. Mary	's,	W. VA	
	permit. Departmitimporta any inju		21. Signature of Fo	uneral Service Li	censee	More	2		-	s of Facili	ity Home	es, Inc		_			
ω_	8 3 E 8 8		M	12/C 1	teidem	10/016	330	5555	Iwin	Knol	ls Ro	oad Co	lumk	oia, M	D 21	045	
			23a. Part1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Approximate Interval Between Onset and Death Years														
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	/Medical Examiner																
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7	uted Insit	i i	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	erlying r injury		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,										7)
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	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	1 ☐ Yes 2 9 ☐ Unknown	No	4∐Preç 9⊡Unk	gnant at time of d nown	leath 5	☐ Other <i>(s</i>	ecify)							,	
P.0	that the sed by detac	P.	Part II. Other signi		s contributing to	death but not res	ulting in the i	underlying o	ause give	en in Part	I.	23e. Did	tobacco	use contribu	ite to the	e cause of de	eath?
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Si Si	tendi eath. tor: A the fu	catic	2 ☐ Accident 3 ☐ Suicide	investiga 6				M		Yes 2	1-						
Division or Vital Records,	or At ifter d Direct in by	Certification:	4 ☐ Homicide		ed 28e. Plac	ce of injury - At ho ding, etc. <i>(Specif</i>	ome, tarm, si	treet, factor	y, office		1	28f. Location City or To	(Street a own, Stat	nd Number e)	or Hural	Houte Numb	er,
L	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier	1 Certifying	Physician: To th	ne best of my kno	wledge, dea	ith occurred	at the tin	ne, date a	nd place	and due to the	e cause(s	s) and mann	er as sta	ated.	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 28 2008 12:50A M Ulysses Green /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Lorien Nursing and Rehab Columbia 8. Date of Birth (Month, Day, Year) Oct. 10,1929 If Under 24 Hrs Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 ★M 2 ☐ F South Carolina 244-34-1191 78 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 XNo Directo Maryland Howard Columbia 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21044 6334 Cedar Lane U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Black þ 3 ☐ Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) North Carolina Elementary/Secondary (0-12) Sanitation Worker Dept. of Public Works 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David Green Flaxie Watson ပ 19a. Informant's Name/Relationship (Type. Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan GreeneWashington 6528 Frietchie Row Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State Metro Crematory 4 □ Donation 5 □ Other (Specify) 2-1-2008 Catonsville, MD 21. Signature of Funeral Service Licenspe 22. Name and Address of Facility
Witzke Funeral Homes, Inc.
5555 Twin Knolls Road Columbia, MD 21045 101050 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Diseane **Physician** end Svage month disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** STELL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine andio my one Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2,☑No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1/2 Natural Injury

Box 68760, P.O. Division or Vital Records. 28a-f show

r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at

72 hours after

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "

permit. Pages 1 and 2 a Department of Health ar Important: If Item 27 is any Injury or other trau

Baltimore, Maryland 21215-0036

death certificate be executed burial-transit and attending physician the for use as cate has been signed by the page 2 should be detached certificate funeral director, After this Certification: 5 Pending investigation Hospital or Attendin thours after death. Funeral Director: Af ely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

^{Year)} 2008

Registrar's Sig

DHMH 17 Rev 1/2001

ORIGINAL

9650

29c. License number

00053150

Santago Rd Suite 110 Columbia ND

29d. Date signed (Month, Day, Year)

1 - For A 2. Date of Death 3. Time of Death Day 9 1. Decedent's Name (First, Middle, Last) **Physician** JANÜARY 5:10P GOLDMAN 2008 HARRIS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY ADELPHI HILL HAVEN NURSING HOME 8. Date of Birth Month Bay 1923 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country)

TV 5. Social Security Number **Funeral** 1 X M 2 □ F TX 464-46-9644 84 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10h County 7 is marked other than "natural", or Items 23a or 28a-f ahow traumatic svent, it a Medical Examinar must be notified at 1 ☐ Yes 2 No MONTGOMERY SILVER SPRING Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12001 OLD COLUMBIA PIKE 20904 Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 1X1Yes 2 □ No If Yes, Give WW II 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ART 4 GRAPHIC ARTIST 18. Mother's Name (First, Middle, Maiden Surname)
Charlotte Braslan 17. Father's Name (First, Middle, Last)
Samuel Goldman Be ould be f Mental I and Mental ss 1 and 2 should be of Health and Ments item 27 is marked **UNOBTAINABLE** UNOBTAINABLE UNOBTAINABLE UNOBTAINABLE 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 89 LAUREL PARK, NORTH HAMPTON, MA JANE KATZ / NIECE other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit, Pages 1 Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State BNAI ISRAEL CONG. 01/11/2008 BALTIMORE, MD ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. Matt Le 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HYYOST 10 WIN **Physician** Cardia BATTON BANGOVED BY LEDICAL EXAMINER disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 4xx4thmia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Precumoria certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No for 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an has page trochanteric Fracture 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No certificate Demontiq 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: or Attending 2 Accident 5 Pending investigation 1 ☐ Yes 2 No Subject tripped over a curb **Unknowh™** 10/11/2007 death. Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) New Hampshire 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Avenue, White Oak, MD Gas Station thin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 1/10/2005 D17843 VAIDM: D 3311 Toledo Terrace # Bloz Hyattsville Md. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 11:55 a м f. Gladys Houston 02 01 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross
5. Social Security Number Rehabilitation & NUrsing Montgomery Burtonsville If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 🖼 F Months Days 88 Director Virginia 25 1919 224-24-9905 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel; or items 23a or 28a-1 ehow eny injury or other treumatic event, it a Medical Exam nature to restitied as once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No MD Bowie Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20721 Completed by Funeral 1006 Devonwood Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🖾 No Specify: Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Grants Dept. Store 6th. Sales representative 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James E. Wade Bessie Hamley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1006 Devonwood Drive Bowie, MD. 20721 <u> Anthony M. Houston/Grandson</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 02-08-2008 Bluewell, VA 4 ☐ Donation 5 ☐ Other (Specify) Restlawn Memorial 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licensee 4217 9th. St. N.W. Washington, d.C. 23a. Part Venter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician eneumoni /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physicien: The law requires that the death certificate be executed the burial-trans **9**nd Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>م</u> roke in the past 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Vinknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? 1 Yes 2.00 1□ Yes 25No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funaral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00054566

State Registrar

FEB 0 6 2008

31. Date filed (Month, Day, Year)

Sunitha Bhogavilli



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

aia Prenue, sicida 1-17, Silverspring, pub 2000

			1 - State of Maryland / De State of Maryland	epartment of F Certificate of	lealth an Death		giene 200	8 03172		
	Physici	ian	1. Decedent's Name (First, Middle, Last)			2. Date of De Month				
¥.	/Medio		Priscilla R. Hurd 4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	r Location of D	Februar	-	1, 2008 10:40 A ^M		
)	Examili	IEI	Shady Grove Nursing Home	Rocky			Montgo			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	(ay) If Under 1 Year	If Under 24 I	Hrs. 8. Date of Bir	th 9.	Birthplace (State or Foreign Country)		
*	Director		321-09-0105 TIME 2MF 91	S.		Nov. 29		ssouri		
vland	now at		10a. State 10b. County 10c. City, Town o	r Location				10d. Inside City Limits		
e Mar	a-f sh tiffied	ctor	Maryland Montgomery Rockv	ille				1 □ Yes 212 No		
vith th	t or 28 be no	Director	10e. Street and Number 9701 Medical Center Drive	10f. Zip Code	0		10g. Citizen of What	Country?		
eath	ns 23 must	Funeral		2085		? (Specify Yes or No	USA	American Indian,		
o after d	or iten niner	Fun	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	13. Was Decedent of H		uerto Rican, etc.)	Black, V	Vhite, etc.		
3-0035 72 hours af	ıral", c	d by	3 XWidowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🖾 No			Specify:	White		
12 L	"natu edica	Completed	(Specify only highest grade completed)	ecedent's Usual Occup Give kind of work done fe. DO NOT use retired	during most of	working	16b. Kind of Busine	ess/Industry		
with K	iene. r than the M	ошр	Elementary/Secondary (0-12) College (1-4or 5+) " 12	Homemaker	2)		Own H	ome		
d be filed	other vent,	BeC	17. Father's Name (First, Middle, Last)			Name (First, Middle,	,			
Val	Menta arked atic e	To E	Joseph Arthur Fotie		Myrt	tle Bright	on			
VICE 12 sh	h and 7 is m traum			lailing Address (Street						
1 and	Healt tem 2 other			7 Tanyard isposition (Name of crematory or other place		Date Date	20c. Location - City			
Dallillor bermit. Pages	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23g or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		143 bullar 2 Doleriation 3 Dreinoval from State	hn's Cemet		5/2008	Ellicott			
	portal		21. Signature of Foreral Service Lightsee	22. Name and Addre	ss of Facility S	terling A	shton Sch	wab Witzke MD 21228		
<u>a</u> 8	6326									
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or he if failure. List only one cause on each line.	enter the mode of dyir	ng, such as car	diac or respiratory a	rrest,	Approximate Interval Between Onset and Death		
	nysician Medical		disease or condition resulting in death) a. Respiratory Failure Instant							
	xaminer		Due to (or as a consequence of): Pneumonia					2 wks		
7		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					2		
ecuted	und transi	Examiner	that initiated events							
ate be ex	ohysician and the burial-transit		Due to (or as a consequence of):							
The law requires that the death certificate be executed	g phys	edical	d							
ath cert	attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	, ,		23d. Date of	. ,			
e dea	the att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	3 □ Ectopic pregnancy 5 □ Other (specify)	n/a		Month	Day Year		
that th	been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause give	en in Part I.	23e. Did t	obacco use contribut	e to the cause of death?		
requires	n sign ald be	d by	Chronic Obstructive Lung Disease	11	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ∑gUnknown					
aw re	s bee 2 shor	Completed	Alzheimer's Dementia		24a. Was an autopsy findings av prior to completion of cau					
T Pe	s certificate has b lirector, page 2 s	Com		to completion of cause of h? Yes 2凶No						
V ILC	sertific ector,	Be (25. Was case referred to medical examiner?	Tout-		Death (Check only o	2 No 1 Ll` nne)			
Phys	r this ral dir	<u>۲</u>	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa 27. Manner of Death 28a. Date of Injury 28b. Tim		4 LAL NUTSIN		dence 6 Other (5	Specify)		
oding 5	th. r: Afte e fune	ıtion	27. Manner of Death 28a. Date of Injury 28b. Time of 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1							
or Attending Physician:	er dea rector by th	Certification:	2 Accident 3 Suicide 6 Could not be determined building, etc. (Specify) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
iga G	urs aft eral Di lled in									
Fo the Hospital	within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, d (Check only one) 1. Medical Examiner: On the basis of examination and/c and manner stated.	eath occurred at the tire investigation, in my o	ne, date and p pinion, death o	lace, and due to the occurred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)		
To the	vithin Fo the comple	Med	29b. Signerare and title of certifier	29c. License	e number		29d. Date signed (M	onth, Day, Year)		
1.2			Kass	D2865	6	1	February 4	, 2008		
3)		30. Name and address of person who completed cause of death (Item 23a) (Type Ravi Passi, M.D. 15225 Shady Grov		8 Roc	kville, M	D 20850			
W	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature							
165	Registr	ar	FEB 0 6 2008							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 4, 2008 **Physician** Horrel1 5:30AM ™ Alton Vernon /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4225 Southwinds Drive Apt. 118 White Plains Charles 8. Date of Birth (Month, Day, Year) Feb. 16, 1924 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ☐ M 2 ☐ F Months Days Hours Min. North Carolina 83 244-16-7324 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 □ Yes 2√1 No Director White Plains Maryland Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 3 20695 U.S.A. 4225 Southwinds Drive Apt. 118 Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 ™ Yes 2 □ No WWII
If Yes Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No White Saltimore, Maryland 21215-0036 Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the Car Salesman Auto Sales d 2 should be filed w th and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Horrel1 Martha Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20695 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau 4225 Southwinds Drive Apt. 118 White Plains MD Patricia M. Horrell (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Trinity Memorial Gardens Waldorf, Maryland 2008 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735 Art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mediate Cause (Final 12ART **Physician** DNGESTIVE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ARDIOMY OLATHY Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death), act Examine certificate be executed and resulting in death) Last Due to (or as a consequence of): physician s the buria Box 68760. Physician/Medical as ding IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the at the detached for 1 ☐ Yes 2 ☐ No O. 9 Unknown ₫. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1 Yes 2 No Division or Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA P 1 Inpatient 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? After t Certification: il or Attending Fafter death. 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital or within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce 29c. License number 211 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Venkat S. Ramanan MD 50 Post Office Road #307 Waldorf, Maryland 20602 31. Date filed (Month, Day, Year) 32 Registrar's Signature FEB 0 6 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend 10f&19b, perFH,08/6, 2/6/08 TI Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 10:37 a.m. Dorothy Highsmith 2008 Ebruan /Medical 4a. Facility Name (If not institution, give street and number, 4b. Gity, Town, or Location of Death c. County of Death Examiner timor If Under 24 Hrs B. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (În yrs. last birthday) If Under 1 Year **Funeral** Hours Months Days Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Md. Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21216 Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after a nand Mental Hygiene.

Is marked other than "natural", or Iter 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ticle 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev lie lames ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Ave. Balto-Md. 21229 21216 fton SOH 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Dwings Mills arrison 4 Donation 5 ☐ Other (Specify) Ellhe 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 30 MINUTES Physician MYOCAR DIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine for use as the burial-trans and Due to (or as a consequence of) High Smith Orothy Division or Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy After this certificate 1∐ Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after dea h. To the Funeral Director, A. dea h. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and little of ceptifier 00051865 16 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BATTIMOREMA CURTIS HUSPITM MD HARLES 57 16NRS 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 FEB 0 6 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death	Reg. No.					
	Physicia /Medic	1 11 ILL VEGILE PTULVAL	2. Date of Death Month Day Year JANUARY 28, 2008 06 45					
	Examin	er 4a Facility Name (If not institution, give street and number) 4b. City, Town, or L	ocation of Death 4c. County of Death					
	Funeral Director	$\begin{array}{c ccccccccccccccccccccccccccccccccccc$	8. Date of Birth (Month, Day, Year) (1 - 2 2 - 60) 9. Birthplace (State or Foreign Country)					
	pug &	Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Insida City Limits					
	ith the Merylar or 28a-f show ne notitied at		1 Yes 2 No					
	20 after death with the Meryle or Neme 23e or 28e-f sho surings must be notified at	10e. Street and Number 10e. Street and Number 1506 11. Marital Status 1 Never Married 12. Marital Status 1 Never Married 11. Merital Status 1 Never Married 12. Marital Status 1 Never Married 15. Marital Status 1 Never Married 15. Marital Status 1 Never Married 16. Street and Number 16. Jip Code 16. Jip Code 17. Jip Code 17. Jip Code 18. Jip Code 19. Jip	10g. Citizen of What Country? U.S. A					
1	1215-0020 Within 72 hours after death with the Meryland ene. than "naturel", or items 23a or 28s-f show he Medical Examinar must be notified at		necify Yes or No- Pilican, etc.) 14. Race - American Indian, Black, White, etc. Specify: Black					
	Baitimore, Maryland 21215-0020 semit. Peges I and 2 should be filed within 72 hours att bepartment of Heelih end Mental hyglene. mportant: If them 27 is marked other than "naturel", or my injury or other treumstic event, the Medical Examples.	3 Widowed 4 Divorced Page or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary (0-12) 17. Father's Name (First, Middle, Last) Willard Moure 18. Mother's Name 198, Give 199, Give	ting 16b. Kind of Business/Industry RSM MCG kidza/					
	Hyge viter	17. Father's Name (First, Middle, Last) AMIN . ASSISTA: 18. Mother's Name	e (First, Middle, Maiden Sumame)					
	Maryiand 2: 12 should be filed v h end Mentai Hygle rie merked other to treumetic event, ib	Willard Moore Shirl						
	ire, Maryland 212: s 1 and 2 should be filed within if Heelth and Mental hyglene. them 27 is marked other than other treumetic event, the M	19a. Informant's Name/Relationship (Type, Print) (185) 19b. Mailing Address (Itr. 1 and Number or Run 1566 XIX WWW.	Ruad Balto Md-21207					
	Baitimore, M permit. Peges 1 and 2 Department of Heelih e important: If item 27 is eny injury or other tre	20a. Method of Disposition 1	Date 20c. Location - City or Town, Stata 02-04-08 Catonsville Mid-					
ı	Depart: Depart import	21. Signature of Funeral Service Licensee) 22. Name and Address of Facility Vaughn C. Green 5151 Batto Natt	Pike Batto Md. 21229					
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arrest, Approximate Interval Between Onset and Death					
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Multiple organ failure Due to (or as a consequence of):	4 weeks					
	7 - / =	Due to (or as a consequence of): b. Pseudomonas bronchopneu	monia 2-3 weeks					
	68760, rifficate be executed by physicien and rifficate and right as the burial-transit	Sequentially list conditions, if any, leading to immediate	1 2 2					
	68760, filcate be ex g physicien of as the burial	cause. Enter Underlying Cause (Disease or injury) that initiated events resulting in death) Last Cause (Disease or injury) that initiated events resulting in death) Last	a-sweeks					
	= 0.0	Sarcoidosis	7 years					
	O et the other to the deat	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?					
	S, P.	4	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown					
17.	DIVISION Of VITAI RECORDS, P.O. BOX To the Hospital or Attending Physician: The lew requires that the death cer within 24 hours after deeth. To the Funeral Director: After this certificate hes been signed by the estendin completely filled in by the funeral director, page 2 should be detached for use	Completed by	24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?					
Bi	The Land	OO	12 Yes 2 No					
3	VITA siclan centifi	W avaminar?	th (Check only one)					
DSON	On Of Iding Phy th. After this funerel of	Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
HC	DIVISI	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	ne Hospita n 24 hours ne Funers	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury at Work? 1 Pacific Natural 5 Pending (Month, Day Year) 28b. Time of Injury M 1 Pes 2 No 28a. Date of Injury 28b. Time of Injury M 1 Pes 2 No 28b. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier (Check only one) 1 Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)					
4	To the To the comp	29b. Signature and title of certifier 29c. License number D 000 4964	29d. Date signed (Month, Day, Year) JANUARY 28, 2008					
	20	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William J. Hicken, M.D., St. Agnes Hospital, Baltim	ore MD. 21229					
	Stat Registra	g 31. Date filed (Month, Day, Year) 32. Togistrar's Signature	, , , , , , , , , , , , , , , , , , , ,					

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 8-00849 State of Maryland / Department of Health and Mental Hygiene Darrell Holmes Certificate of Death 1- For State Registrar 2. Date of Death ient's Name (First, Middle,Last Physician/ Month Day January 30, 2008 1638 hrs Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore University Hospital Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours Min 212-35-8584 Country) Director XM. 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County any 10a. State Yes 2 No 28a-f show more notified at once. nours after death with the Maryland Director 10g. Citizen of What Country 10e. Street and Number 1223 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Was Decedent Ever in U.S. Funeral 11 Marital Status White, etc Armed Forces? 1 X Never Married 2 Yes Yes 2 X No specify: If Yes, Give Yea Widowed Divorced è 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) ges I and 2 should be filed within 72 I the Medical 21215-0036 en Name (First, Middle, Maiden Surnam Name (First, Middle If item 27 is marked or other traumatic event, or Town, State, Zip Code) 19b. Mailing Add (Street and N 21223 enrose evanlie Town State Place of Disposition (Name of cemetery 20a Method of Disposition Baltimore, cremetory or other place) 2 Cremation 3 Removal from State permit. Pages 1 Department of F mportant: er Specify ervice Licensee Approximate Interval cardiac or respiratory arrest, shock, or heart complications that caused the death. Do not enter the m 23a, Part I, Enter t **Physician** Between Onset and one cause on each line failure. List onl /Medical Death a. Gunshot wound to the head Immediate Cause (Final disease amine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical AMENDED UNPENDED attending physician or use as the burial -23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Yes 2 ✔ No 3 Probably 4 Unknown à Completed Records, 24b. Were autopsy findings available should 24a. Was an prior to completion of cause of autopsy death? performed' certificate has Yes 2 1 V Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medica **Division of Vital** Be examiner? Other₄ Hospital: Residence 6 ER/Outpatient 3 V DOA Nursing Home 5 Inpatient this 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred funeral 28a. Date of Injury (Month Day Year) Jan 30, 2008 28b. Time of Injury After 27. Manner of Death Subject shot Certification: 1609 hrs Yes 2 V No Pending 24 hours after death. Funeral Director: telv filled in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be or Town, State) 2205 Penrose Avenue, Baltimore , MD Suicide determined (Specify) Townhouse / Rowhouse 4 V Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the within. and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 31, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 3 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year) State Registrar ORIGINAL OCME

Division or Vital Records, P.O.

DHMH 17 Rev 1/2001

Jessica Ratra 31. Date filed (Month, Day, Year) FEB 0 6 2008 State Registrar

29b. Signature and title of certifier

0

D18947 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7527 Greenway Center Drive Greenbelt, MD

29c. License number

29d. Date signed (Month, Day, Year)

			For State Registrar	State of Marylar			of Health a of Death	nd Ment	al Hygie	7 11 11 13	03178		
	Dhysisi	20	1. Decedent's Name (First, Middle, Last)					ate of Death	Day Year	3. Time of Death			
	Physici: /Medic		Mildred C. Harris					FE	B. 2,	Day 2008 Year	9:26 a M		
	Examin	er	4a. Facility Name (If not institution, give s				wn, or Location of			4c. County of Death			
			Transitions Nurs 5. Social Security Number 6. Sex		last birthday)	If Under 1	kesville		ate of Birth fonth, Day, Yo		place (State or Foreign intry)		
	Funeral Director			M 2	Yrs.	Months D	ays Hours	Min. (MA	fonth, Day, Yo		yland		
	ס		Usual Residence of Decedent								10d. Inside City Limits		
	show	-	10a. State 10b. County	100. 01	ty, Town or Lo						1 ☐ Yes 2 No		
	Be-f	Director	Maryland Carroll			10f. Zip Co	esville		100	. Citizen of What Cou			
	with the or		10e. Street and Number 7309 Second Av	eniie		101. Zip Ct	21784		109	USA	y.		
	ns 23	Funeral		2. Was Decedent Ever in U	J.S. 13.	Was Deceden	t of Hispanic Orig Cuban, Mexican,	jin? (Specify Y	es or No-	14. Race - Amer			
39	in 72 hours after death with the Maryland "naturel", or items 23a or 28e-f show isdical Examinat must be invitibed at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1		If Yes, specify 1 ☐ Yes 2 X		, Puerto Hican	, etc.)	Specify: Wh:			
21215-0036	2 hou	Completed	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usual C	Occupation	of working	16	b. Kind of Business/la	ndustry		
21	c * 39	nple.	Elementary/Secondary (0-12)	College (1-4or 5+)			done during most retired)	g			14.1		
7	73 -		12		Sean	nstress		da Nama /Fim		stom Drape iden Sumame)	ery Maker		
Maryland		Be	17. Father's Name (First, Middle, Last) Joseph R. Edmo	ndson				Rose C1					
Ž	2 should be and Menta Is marked reumatic ev	ဥ	19a. Informant's Name/Relationship (Type		19b. Maili	ng Address (S				City or Town, State, Z	ip Code)		
≥	nd 2 s lith ar 27 is r treu		Raymond Clayton Co							lle, MD 21			
<u>6</u>	ss 1 and 2 of Health item 27 l		20a. Method of Disposition	20b.	_	osition (Name matory or othe	The second second second	Date		c. Location - City or T			
Ë	Page nent o nt: If		1 ☐XBurial 2 ☐ Cremation 3 ☐ Ro 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State				2/7/08	F	inksburg,	MD		
Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot once.		21. Signature of Funeral Service License	malal	Н ²	2. Name and A aight F	Address of Facility uneral F	dome & sesvill	Chapel	21 ^P 84 (410	0-795-1400)		
			23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the dea							Approximate Interval Between		
1	nysician /Medical Examiner		Immediate Cause (Final disease or condition										
			resulting in death) Due to (or as a consequence of):										
		<u>.</u>	Sequentially list conditions.										
\overline{I}	ted nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Unuerlying Cause (Disease or injury	quence of):				-					
V.	execu n and ial-tra	Examine	that initiated events c. resulting in death) Last Due to (or as a consequence of):										
87605	cate be executed physician and the burial-transit	edlcal											
9	feath certifica attending phy for use as th	Medi	IF FEMALE:							-			
Вох	ath ce ttendi or use	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1☐Live birth 2☐Fet	al death 3	⊒Ectopic preg				23d. Date of deliment	very Day Year		
	at the dea by the a stached f	yslc	1 ☐ Yes 2 ☑No 9 ☐ Unknown	4☐ Pregnant at time of 9☐ Unknown	death 51	☐ Other (spec	rfy)						
ls, P.O.	es tha	by Ph	ρ	þ	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	underlying cau	se given in Part I.	2		cco use contribute to	the cause of death?
ord	w requir been si should	Completed		etes mellitus									
3ec	a - a	Idm	Divoet	ej "/[[[LIVII				24a. Was an autopsy performe	ed? death?	topsy findings available completion of cause of		
a	icien: The l certificate ha rector, page		Of Was area referred to modical				OC Disease			No 1 ☐ Yes 2 ☐ No			
₹		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 ☐ Inpatient 2 ☐] ER/Outpatie	nt 3□ DOA	Othor	of Death (Che			eifv)		
Division of Vital Records,	e fe	-	27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Year)		Injury at Work?	28d. I	me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred					
Divisi	lel or Attending s after death. el Director: After ed in by the funer	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	B Disco of laive. At home form street feeton, office					28t. Location (Street and Number or Rural Route Number, City or Town, State)				
_	To the Hospitel or within 24 hours after Yo the Funerel Director completely filled in b	edical Co	29a. Certifier 1. Certifying Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification	sician: To the best of my knier: On the basis of examin	nowledge, dea nation and/or in	th occurred at nvestigation, in	the time, date and my opinion, deat	d place, and d th occurred at	lue to the cau the time, date	ise(s) and manner as e and place, and due	stated. to the cause(s)		
	ithin 2 the othe	Med	29b. Signature and title of certifier	and manner stated.	icense number		290	. Date signed (Month, Day, Year)					
	F 3 F 8		/			17)437	25	_	2/4/6	8		
7	J		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type	, Print)	.0	. 100	. 1				
	J			HMUOD	19 12	idye	Kord	VVC.	1-mir	uster n	8		
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 🤈 🗋 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Black Henry 3:00p. M Virginia 01 31 2008 Pricie /Medical 4b. City, Town, or Location of Death
Towson 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number) **Examiner** (Hospice) Gilchrist Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03 25 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🗓 F 86 21 MD 218-20-4660 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar mine. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 □ No Baltimore MD NA Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21207 U.S.A. 4207 Springdale Ave Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Š Specify: Black 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12th grade College (1-4or 5+) House Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Linda Raisin Asbury Black ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21215 Beverly Henry-Daughter 2601 Ruscombe Lane, Baltimore, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore National 2/5/08 Baltimore, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md Sign ure of Funeral Service Licensee 21215 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER err **Physician** metastat di as or condition res lin g in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner attending physician and for use as the hirial toresulting in death) Last The law requires that the death certificate be exec Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4□Pregnant at time of death 5 Other (specify) ed by the a detached for 9 Tinknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed2 After this certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 05 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 24 hours after death e Funeral Director: the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide To the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number mum 31,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Brint) N. Chiles St. falto-Md 2(206 Gomo 6701 A. Kiley 31. Date filed (Month, Day, FEB 32. Régistrar's Signature

Registrar

Year) 6 0

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 29, 2008 Physician 4:32 AM M John C. Ilq /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Holy Cross Hospital Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Country) **Funeral** Days (Month, Day, Year) 05/11/1934 Hours 1'**⊠** M 2□ F 73 295-30-9122 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show notified at 1 ☐ Yes 2 No MD Montgomery Silver Spring Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò pe 20904-United States 3114 Gracefield Rd. 23a 72 hours after death Medical Examiner must Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, or items, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: White þ 3 Widowed 4 Divorced 'natural' Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Computer Technology Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Director traumatic event, the I 2 should be filed w h and Mental Hygier 7 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edith Moser permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked of any Injury or other traumatic ew Charles Ilg ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Douglas A. Ilg/Son 14301 Vivaldi Ct. Burtonsville, MD 20866-20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb 4 1 Burial 2 □ Cremation 3 MRemoval from State Erlangar, Kentucky Forest Lawn Mem. Park 2008 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22 Name and Address of Facility
Rapp Funeral & Cremation Services M00382 Rapp Funeral & Cremation Serv 933 Gist Ave. Silver Spring,

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 933 Gist Ave. Silver Spring, Maryland 20910-Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardenc JUDEN /Medical Due to (or as a consequence of): **Examiner** SPONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of Due to to Examine requires that the death certificate be executed burial-transit YPERTENSION and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical as the I IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Yes 2 No P.0. the detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No ABDOMINA 3 Probably 4 Unknown 1 Yes cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 2MNo 1∐ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No Hospital: 1 ☐ Yes 1 Inpatient 2€ ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral. funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 FOREST GLEN DA DEONARINE ANAND MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 6 2008 State

DHMH 17 Rev 1/2001

Registrar

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Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and

		Please	Type or Print in					•		9	
		For State	State of Maryl					Mental Hy	/giene		00101
		Registrar 1. Decedent's Name (First, Middle, Las		-	Certificat	e of	Death	2. Date of D	Reg. No	2008	03181
Physic		1	ns m					Month	Day	Year 2009	3. Time of Death
/Medi Exami		4a. Facility Name (If not institution, give	e street and number)		4b. City	Town, o	r Location of Death	Feb.	4c.	County of Deat	
		Cienesis Home				,	Home			Cit	7
Funeral		5. Social Security Number 6. S 1 2 1 3 - 0 5 - 8 9 5 7	₽ M 2□F	yrs. last birtl	hday) If Unde Months	Days	Hours Min.	8. Date of Bi (Month, D	ay, Year)	Co	hplace (State or Foreign untry)
Director		Usual Residence of Decedent	90					Mar. 2	20,1	917 Ma	ryland
rryland show	_	10a. State 10b. County		City, Town							10d. Inside City Limits
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r dea	nue	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S.	13. Was Dece	dent of H	lispanic Origin? (Span, Mexican, Puert	pecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, White	e. etc.
ours afte	2	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 □ Yes	2 <mark>⊋</mark> No	Specify:			Specify	k
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perinification in the Maryland A I I I I I I I I I I I I I I I I I I	Be	12th grade 17. Father's Name (First, Middle, Last) Charles Johnso					18. Mother's Nam		e, Maiden	Surname)	
shoul Me mark	2	19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing Addres	s (Street	and Number or Ru	ral Route Num	ber, City o	or Town, State, 2	Zip Code) 21229
and 2 salth a		Alvin Johnson/	Son	80	1 Mt.	Hol]	ly Stree	et Bal	timo	re,Mar	yland
or other		20a. Method of Disposition 1 Surial 2 Cremation 3 C	Dames of from Chate	cemeter	Disposition (Na y, crematory or	other pla		Date		ocation - City or	
t. Partmen		4 □ Donation 5 □ Other (Specif		ling I			Park 2/8			•	Maryland
Depariming Department of the police.		21. Signature of Funeral Service Licer	Tario		5240	na Adare Reis	sterstov	ntman-1 vn Rd	Harr Balt	ris Fur imore,	eral Home Md 21215
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Physician	1	Immediate Cause (Final disease or condition	ASCID							9	Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a cor	nsequence o	of):			-			
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death atten	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death	3 □Ectopic p 5 □ Other (s		у			23d. Date of de Month	Day Year
by the	hysi	9 Unknown	9□Unknown								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions of	contributing to death but not	_			ven in Part I.				o the cause of death?
aw requir	Completed	A. Fis						24a. Wa		24b. Were a	utopsy findings available
ding Physician: The lav h. After this certificate has funeral director, page 2:	m o								opsy formed? 2 ☑ No	death?	completion of cause of 2 □ No
clan: ertific ector,	Be (25. Was case referred to medical examiner?					26. Place of Dea				
Physical this of all directions and directions are all directions are	2	1 ☐ Yes 2☐ No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Out		OA Oth 28c. Inju	4 Nursing H	ome 5 Res		6 ☐Other (Spe	cify)
dlng th. : After	tion	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea		njury M	Wo	rk? Yes 2∐No	200. Describe	e now inju	ry occurred	
VISIN VISING VIS	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - building, etc. (S)	At home, far pecify)	m, street, factor	y, office			(Street a		ural Route Number,
Italo rai Di											
To the Hospital or within 24 hours afte To the Funeral Discompletely filled in	edical	29a. Certifier 1 CertifyIng Pt (Check only 2 Medical Examone)	nysician: To the best of my miner: On the basis of exa and manner stated.	/ knowledge mination and	, death occurred d/or investigatio	d at the ti	ime, date and place opinion, death occu	e, and due to thurred at the time	e cause(s e, date an	s) and manner and place, and du	s stated. e to the cause(s)
To tl	ž	29b. Signature and title of certifier			29	_	se number		29d. Da	ate signed (Mon	th, Day, Year)
		Wand Kee	on go			1) 3	31295			16/09	
3		30. Name and address of person who	completed cause of death	(Item 23a) (Cha 21s	Type, Print)	J. L	4242	7 6 12.5		nd	21204
St	ate	31. Date filed (Month, Day, Year)	6 701 N 32. Registrar's S	Signature	44.			,			
Regis		FEB 0 6 2008	Blesid &	Ages		-					

08-00850 Charles D. Jones

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 03182

nanes D. sones		For State eqistrar	Certific	ate of De	eath		Re	g. No.	
Physician	/ 1	. Decedent's Name (First, Middle,Last)					Date of Deat Month	Dav Year	3. Time of Death 1505 hrs
Medical Examine		Charles D. Jones		- 1			January 30), 2008 4c. County of	
	4	a. Facility Name (if not institution, give street Atlantic General Hospital	and number)		City, Town, or L e rl in	ocation of i		Worceste	r
Funeral	5	5. Social Security Number 6. Sex	7. Age (In yrs. last bir	′′′	Under 1 Year	if Under		th(MM/DD/YYYY)	Birthplace (State or Foreign
Director		227-98-0210 1XXM 2	F 46	Yrs.	Months Days	Hours	Min. April 1	1	Country) VA
Å.	_	Usual Residence of Decedent 10a. State 10b. County	10c. City. Town	or Location					10d. Inside City Limits
d how any		VA Wythe	Max Me						1 Yes 2 No
he Maryland or 28a-f show	ᄋᆫ	I0e. Street and Number			f. Zip Code		1	0g. Citizen of Wha	at Country?
th the M 23a or 2 notified	5	303 Olive Lane			24360)		USA	
5-0036 led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once.	~ I	,	/as Decedent Ever in U.S. rmed Forces?	13. Was De	ecedent of Hisp specify Cuban,	panic Drigir Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	- 14. Race - White,	- American Indian, Black, , etc.
	틸	Never Married 2 Married 1	Yes 2 XXNo	1 70	s 2 XX No	snecify:		Specify:	1411-5-1-
s afte	ଚ -	3 Widowed 4 XXDivorced If Yes, or Date 15. Decedent's Education (Specify only high	(S)	Decedent's I	Usual Occupati	on (Give ki	nd of work done	16b. Kind of Bus	White
215-0036 be filed within 72 hours after ntal Hygiene, "natural", rked other than "natural", ent, the Medical Examine.	Completed		ollege (1-4 or 5+)	during most	of working life.	DO NOT u	se retired)		
336 thin 7 ne.	린	11	P	lumbing	/ Electr	ical		Contra	
15-00; Tled withi Hygiene d other if		17. Father's Name (First, Middle, Last)					Name (First, Middle,	Maiden Surname)	
be fi nrtal rked	Be	Charles Thomas Jones		Oh. Mailing As	ddrore (Stree		rta Dean per or Rural Route Nu	mher City or Town	n. State, Zip Code)
ID 2 Should and M 77 is m.	٩ſ	19a. Informant's Name/Relationship (Type, Pr							, , , , , , , , , , , , , , , , , , , ,
≥ chi na in di Z	-	Brenda Porter 20a. Method of Disposition				netery,	adows VA 2 Date	20c. Location -	City or Town, State
2 = ₹ 5 5		1 Burial 2 XX Cremation 3 XX Re	moval from State	atory or other ew Creme			Feb 4, 2008	Baltimor	e 11D
Baltimo permit. Page Department or Important: injury or oth	H	4 Donation 5 Other Specify 21. Significant Funeral Service Licenses	Dayvi	22 Nam	ne and Address	of Facility		Datemore	5, 110
Ba perm Depa Imp	. 2	- Cuecony	M01148	1,20	nk Funera 5 Crain H	June C	Clan Russia	MD 2106	1
Physician		23a. Part I. Enter the disease, or complication failure. List only one cause on each line	ns that caused the death. Do	not enter the	mode of dying,	such as ca	rdiac or respiratory a	rest, shock, or hea	art Approximate Interval Between Onset and
aminer	- 1	Immedia Cause (Final disease a. Pnet	monia						Death
annie			(or as a consequence of):						
	닐	Sequentially list conditions, if any, leading to immediate b. Due to	(or as a consequence of):						
	Examine	cause. Enter Underlying Cause	(or as a consequence of):			_			_
red nsit	Exa	events resulting in death) Last d.	(or as a consequence or).						
iox 68760, eath certificate be executed attending physician and for use as the burial - transit	Medical		Ba,PII,27,perME,g	876 2/	11/08 TT				
760, cate be		IF FEMALE: 230	. If yes, outcome of pregnand	У				23d. Date of	<u> </u>
687 certific nding	sician/	23b. Was decedent pregnant in the past 12 months?	Live birth Pregnant at time of death	- =	death 3 (Specify)	Ectopic	pregnancy	Month	Day Year
Box e death of the atter		1 Yes 2 No 9 Unknown 9	Unknown	5 Othe	(Opecary)			1	
O. E at the d by the stached	/ Phy	Part II. Other significant conditions conti				given in Pa			ribute to the cause of death? Probably 4 Unknown
ires th	d by	Atherosclerotic card	iovascular diseas	æ; cirr	hosis		24a. Wa		Were autopsy findings available
ords * requires to the second of the second	Sete						aut	opsy	prior to completion of cause of death?
Reco	Completed								1 Yes 2 No
ian:	Be C	25. Was case referred to medical examiner?				Other	(Check only one)	Residence 6	Other:
' Vit		1 ✔ Yes 2 No		/Outpatient b. Time of Inj		ury at Worl	Nursing Home 5	e how injury occur	
n of	Ë	27. Manner of Death 1 X Natural 5 Pending	(Month, Day,Year)	o. Time of my	· / _ ′	Yes 2			
Sio Atten r death ector: by the	cati	2 Accident Investigation	28e. Place of Injury - At home	, farm, street,	, factory, office	building, e			ber or Rural Route Number, City
Divi	Certification: T	3 Suicide 6 Could not be determined	(Specify)				or Town	, State)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	a C	29a. Certifier 1 Contifuing Physician:	o the best of my knowledge,	death occurre	ed at the time,	date and pl	ace, and due to the ca	ause(s) and manne	er as stated.
Fo the vithin Fo the comple	Medical	and	he basis of examination and/ manner stated.	or investigatio					ned (Month, Day, Year)
FAFS	Ž	29b. Signature and title of certifier	20			nse number C.M.E.		January 3	
		in in.	1 4	_	0.0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		- a. idar y o	
		30. Name and address of person who comp Ling Li, MD Assistant Medic		a) enn Street	t, Baltimore	, MD 21:	201		
	ata		32 Registrar's Signature	A					
St Regist	ate trar		Rose H	A soul	<u> </u>				
DHMH 17 Rev 1/2	001	LED 0 0 m	Mary Trans	ÖRİGINAL	_		(CME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2008 FEBth 3, 4:55 p M Barbara Ellen Jones 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Carroll Carroll Hospital Center Westminster Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Maryland 215-28-8923 75 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 🛣 No Sykesville Maryland Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21784 12800 Amberwoods Way 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes M No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) School Bus Bus Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth M. Cookerly William H. Pomeroy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1201 Conestoga Ct. Mt. Airy, MD 21771 Michael Hodge/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/7/2008 Marriottsville, MD Mt. View Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD P.A. 21784 (410-795-1400) Warred Mollmale Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pericardia disease or condition resulting in death) Due to (or as a consequence of): out to (or as a consequence of): Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 4□Pregnant at time of death

Physician /Medical Examiner

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Be

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Funeral

Director

7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or Items 23a

Baltimore, Maryland 21215-0036

burial-transi the attending pl signed by the a

Hospital or Attending Physician; The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

IF FEMALE: 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

(Check only

Examine Physician/Medical þ Be Completed Certification: To

resulting in death) Last 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

9 Unknown

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown

24a. Was an autopsy 1∐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

29b. Signature and title of certifier

20066184

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EID ALMUTAIRY M.D. 200 MEMORIAL AVE, WESTMINSTER, MD 21157 31. Date filed (Month, Day, Year)

State Registrar

FEB 06 2008



filled in by the f

within 24 hours at To the Funeral C completely filled i

Medical

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** <u>10:</u>30a [™] 01 30 2008 Louise Jennings /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Reisterstown Future Care Nursing Home If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1 M 2 X Director 85 03 16 22 VA 224-30-2701 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ed at r 28a-f sh notified 1 ☐ Yes X☐ No Reisterstown Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number items 23a or 2 iner must be n Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 21136 U.S.A. 12020 Reisterstown Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☑ No Specify Specify Black ģ 3€ Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cook Synagogue N/A N/A Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Anna Owens Channel Owens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21223 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health ar Important: If item 27 Is any Injury or other trau Stephanie Owens-Granddaughter 531 S Catherine Street, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Carmel 2/5/08 Baltimore, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or healthfailure. List only one cause on each line. Approximate Interval Between Onset and Death ARTERIOSCIEROTIC CARDIOVASCILAR Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit and A Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 0 Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division or Vital Records, P.O. the detached 9□Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 No 1 TYes 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be av No Other: 41 Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 1 🗌 Yes 1 Inpatient rsing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day 28h Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After Year) 1 Natural 2 Accident 5 ☐ Pending investigation To the Hospital or within 24 hours after death.

To the Funeral Director Af 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIEHUE 341 LORE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar FEB 06 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11 11 8 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 02 **Physician** 1230AM UACKSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MARYLAND RANDAUSTOWN CARE OLD (OURT FUTURE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 KF Director 217-20-0396 101 1906 Usual Residence of Decedent the State 10b. County 10c. City, Town or Location 10d. Inside City Limits show treumatic event, the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director Baltimore MD NA 28e-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 3200 Howard Park Ave 21207 or Itams 23a U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. be filed within 72 hours after a ntal Hygiene. ed other than "natural", or Ital 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No 3 ₩ Widowed 4 Divorced 2 Specify: Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Goldberg Dept. 12th grade College (1-4or 5+) Salesperson Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental I Dulah Luke Frank E. Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health itam 27 I 3200 Howard Park Ave, Baltimore, Md Douglas Boone-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If its any injury or of ance. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 2/7/08 Woodlawn Baltimore Co, 21. Signatus of Funeral Service Licentee March F/H West thum Pson 4300 Wabash Ave, Baltimore, 21215 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Poset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** disease hrow /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Dive to (or as a consequence of): or Attanding Physician: The law requires that the death certificate be executed inding physician and use as the burial-transit Box 68760, resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de. 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 10

9 Unknown Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. I been signed by the should be detached 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the upderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 1 ☐ Yes 21 funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: Certification: To 1 Inpatient Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation within 24 hours after death. To the Funaral Diractor: A 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide o the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 12511 lloel 20, crossroads brine suite 101 wingshill 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kawaja anoora

State Registrar

31. Date filed (Month, Day, Year)

FEB 06

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 01: 10 PM onnsor JANURARW 31, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner nion Memoria 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 M 2 V 220-76-4830 56 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show rai", or Items 23a or 28a-f shov Examiner must be notified at 1 Pres 2 No Director Baltimore 10e. Street and Number 10g. Citizen of What Country? 3731 Ellerslive Ave a 12 18 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Mo Specify: B/GC þ 3 ☐ Widowed 4 ☐ Divorced the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) the sabled Disablec Department of Health and Mental Hygis Important: If Item 27 is marked other any injury or other traumatic event, th once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ahnSon 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2520 Pot Spring And Timonium, MD 21093 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 22. Name and Address of Facility Vaugna C. Greene Fueral Services
4905 York Ad Baltimore, MD 21212 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee MO 1363 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician -SOMATION NEUMONIA disease or condition resulting in death) /Medical Due to or as a consequence of): **Examiner** DRONATILL Sacus mostly list cancelling if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed DIABETES burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the burial the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the aid be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has t irector, page 2 s autopsy performed? Yes 2 No 1☐ Yes after death.

Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Natural 2 Accident 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Tyes 3 Suicide 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1/ HOSKINS MIDN 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 118

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3:00 AM Yacoub A. Kahkejian 1/23/2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8420 Flower Hill Terrace Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 □ F 85 214-04-6628 Director 5/28/1922 Syria Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event: the Martinal Control of the 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Director Montgomery Gaithersburg 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 20879 USA 8420 Flower Hill Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: Armenian þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Driver Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Armenag Kahkejian Yeranig Ferejian ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8420 Flower Hill Terr. Gaithersburg MD 20879 Alice K. Kahkejian / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring MD Gate of Heaven Cem. 1/25/2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 933 Gist Ave. Rapp Funeral & Cremation Ser. Silver Spring MD 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a METASTATIC 3TATZC99 CANCER Intrown /Medical Due to (or as a consequence of): Examiner b. INTRACERERRAI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed Due to (or as a consequence of) ARTERY resulting in death) Last Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 X No 3 Probably 4 ₭ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 【 No 24a. Was an autonsy 2**6** No Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home ၉ 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 5 Residence 6 □Other (Specify) 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification: To the Hospital or Attending ★ Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 (Directifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockuslle Pike 4401 Rockustle MD 20852 DONMEZ 31. Date filed (Month, Day, Year) Registrar's Signature State 6 2008 FEB Registrar

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Division or Vital Records, P.O. Box 68760, ~

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 34 A M Gus Kastrunes 2008 Febrary /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Posedale
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. FRHAKLIN SQUARE HOSPITAL CENTER Baltimore 8. Date of Birth (Month, Day, Year) 03/21/1930 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 → M 2 □ F **Funeral** 216-28-8684 Greece Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r 28a-f show notified at 1 ☐ Yes 2 XNo Maryland Baltimore Essex Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or ? must be n 21221 U.S.A. 14 Homberg Avenue Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Korea If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married 6 1 □ Yes 2**⊠** No Baltimore, Maryland 21215-0036 Specify: White Specify þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural" Completed the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n, any injury or other traumatic event, the Mexitone. Elementary/Secondary (0-12) College (1-4or 5+) Union Tradesman Painter 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unk. Despina Andreas Kastrunes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14 Homberg Avenue, Baltimore, Maryland 21221 Dolores Kastrunes (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 02/07/2008 |Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 W 23a. Far1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheroscleroti Cardiovascula Accea **Physician** disease or condition resulting in death) Tyear /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of) attending physician for use as the hirial Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed HUBETTE 2 10 25. Was case referred to exical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After t 1 Natural 5 Pending investigation М 1 □ Yes 2 □ No 2 Accident Director: d in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00 8 Co H35593 30. Name and address of person of completed cause of death (Item 23a) (Type, Print) Ave, Balto. John 32 Pegistrar's Signatur 31. Date filed (Month, Day, Year) State a Sure 2008 FEB 0 6 Registrar

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State of Maryland / Department of Health and Mental Hygiene

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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 □ Never Married 2 □ Mar 3 🗷 Widowed 4 □ Divorced	ried 1 [Yes 2 X es, Give ar or Dates:		.=-21	1 ☐ Yes 2		Specify:			S	anneite.	hite	
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	i		30. Name and address of person	n who complet	ed cause of	death (Ite	m 23a) (Typ									
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Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3315 KANJAC ROAD, BALTIMORE, MD LENORA KREW / WIFE 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State ARCTNGTON CHIZUK 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/05/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) NEUMONIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Completed by Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) Yes 2 No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 3□ DOA 2 1 npatient 2 ER/Outpatient 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation (Month, Day 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

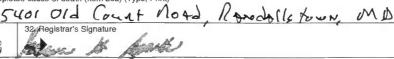
State Registrar

31. Date filed (*Month, Day, Year*)

FEB 0 6 2008

MIller

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DHMH 17 Rev 1/2001

Steven

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 20b per fh 8876 2-6-08 vt.
State of Maryland / Bepartment of Health and Mental Hygiene 2008 State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 4, 2008 **Physician** 12:02A M **JAMES** LANDERS February ANTHONY /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Greater Baltimore Medical Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) October 30, 1923 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days **X** M 2□ F Pennsylvania 84 193-14-6803 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County with the Marylar permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 □Yes XX No Maryland | Baltimore Baltimore Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 USA 9640 Mason Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes AM No If Yes, Give Year or Dates: 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XX No Specify: White Maryland 21215-0036 Specify: Completed by XX Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Social Security Administration Branch Chief 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ James Landers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9640 Mason Avenue Baltimore, Maryland 21234 Richard Michael Landers Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dat 2008 20a. Method of Disposition XXBurial 2 □ Cremation 3 ☐Removal from State Dulaney Valley Mem Gardens Feb 8, 1908 | Timonium, Maryland □Donation 5 □ Other (Specify) Licepsee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc ionature of Funeral Su was 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** nours /Medical **Examiner** eneralized debite Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 5 ☐ Other (specify) 1 □ Yes 2 □ No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 3 ☐ Probably 4 ☐ Unknown diteite, 24b. Were autopsy findings available prior to completion of cause of death? peritoniti 24a. Was an autopsy performed? Yes 2 10No 2 No 1□ Yes To the Hospital or Attending Physician: ors after death.

eral Director: After this certificatile in by the funeral director. 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural
2 Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar AARON J CHARRES MM

2008

31. Date filed (Month, Day, Year)

ANDERS, Antonny 2/4/08

6701 Nelveries

32. Registrar's Signature

			For State	State of M	arylan		rtment of F		ınd Me			08	03192
			Registrar 1. Decedent's Name (First, Middle, Last)				incate or	Dealii	-	Re . Date of Deat	g, 140, -		3. Time of Death
П	Physici	an								Month	Day	Year ೧ 0	8:55 P. M
	/Medic		Walton R. Loweree 4a. Facility Name (If not institution, give s)		4b. City, Town, o	r Location of		rebruar	ary 3, 2008 8:55 P. M		
	Examin	er	224 Gralan Road	,			Catons				Bal	timo	re
	Funeral		5. Social Security Number 6. Sex	7. A	ge (In yrs. I	last birthday)	If Under 1 Year	If Under 2		Date of Birth	Vaari	9. Birthr	place (State or Foreign
	Director		220-20-1041	ŁM 2□F	77	Yrs.	Months Days	Hours	Min.	(Month, Day, Feb. 22	, 1930	Mar	yland
	p.		Usual Residence of Decedent		100 City	, Town or Lo	nation						0d. Inside City Limits
	anylar show d at	<u>_</u>	10a. State 10b. County										1 ☐ Yes 2 XNo
	he M 18a-f otifie	Director	Maryland Baltimore		C	atonsv	ille 10f. Zip Code			1/	og. Citizen of W	hat Cour	otn/?
	with t		10e. Street and Number				212	20		"	USA	iai coui	itty:
	eath ns 23 must	Funeral	224 Gralan Road	12. Was Decedent	t Ever in U.	S. 13. V			nin? (Speci	fv Yes or No-		- Americ	ean Indian,
	fter d	듄	1 ☐ Never Married 2 Married	Armed Forces 1 ☐ Yes 2 🔀	?		Vas Decedent of H		í, Puèrto Ri	ćan, etc.)		, White,	
93	ursa al',o Exam	þ	3 ☐ Widowed 4 ☐ Divorced	if Yes, Give Year or Dates:		1	I□Yes 2XINo	Specify:			Specify:	WILL	te
2-0	72 ho natur iical	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)		16a. Deced	lent's Usual Occup kind of work done OO NOT use retired	ation during most	t of working	,	16b. Kind of Bus	iness/In	dustry
2	ithin De.	현	Elementary/Secondary (0-12)	College (1-4or				-		.	T71 - 1	۹.	
7	lygier lygier ner th		47 Fatheric Name (First Middle Land)	4		Manuta	cturers				Wholesa Maiden Surname		
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene, is marked other than "natural", or Items 23a or 28a-f show aimarke other, the Medikal Examiner must be notified at	Be	7. Father's Name (<i>First, Middle, Last</i>) Edgar Vincent Loweree, Sr. Cleo Mae								alderi obiriame	,	
ž	hould d Me mark maric	ပ	19a. Informant's Name/Relationship (Tv.	-		19h Mailin	g Address (Street				City or Town 5	State Ziu	Code)
Z	d2 th a 7 is		Joan C. Loweree	Wife			Gralan R						21228
<u>6</u>	permit. Pages 1 and 2 Department of Health Important: If Item 27 i any Injury or other tra		20a. Method of Disposition		20b. P	Place of Dispo	sition (Name of natory or other pla	201	Da	te	20c. Location - 0	City or To	own, State
JOE	Pages nent of h ant: If Ite ury or o		1 ☐ Burial 2 【***Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (<i>Specify</i>)	emoval from State	⊃ I	-	ematory	1	2/5/2	800	Catonsv	111e	, Maryland
altimore,	permit. F Departm Importar any Injur		21. Signature Temoral Service License	90		22	. Name and Addre	ss of Facilit	Ster	ling As	shton So	hwal	b Witzke
m	Der July Ber		Call) N	10/29	0	Funeral H 630 Edmo	lome o	i Cat	onsvil. ue: Cai	le, Inc.	e.]	MD 21228
F	-		23a. Part1. Enter the disease, or complishock, or head failure. List only or	cations that cause	ed the death	h. Do not ent	er the mode of dyi	ng, such as	cardiac or	respiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	4.			Trafaci	tom				- 4	Onset and Death
1	/Medical		resulting in death)	Due to (a conseq	uence of):	MILEN	710.	`				3 70170
	Examiner		Sequentially list conditions	_Cor	ena	Ar	ten Y	1800	Se_				1140
7	ъ t	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	s a conseq	uence of):)						•
V	ecute and trans	Examiner	that initiated events resulting in death) Last	Due to (or a	0.0000000	uanno of):							
8760,	cate be executed physician and the burial-transit	<u> </u>		Due to (or a	s a conseq	defice off.							
87	cate physi	dical		d						<u></u>			
9 X	death certifica aftending ph for use as t	Physician/Me	IF FEMALE:	3c. If yes, outcom	e pf pregna	ancy					23d. Date	of deliv	rerv
Box	aften for u	cian	in the past 12 months?	1☐Live birth 4☐Pregnant	2 Feta	ıl death 3 ☐	Ectopic pregnand Other (specify)	у			Mor		Day Year
o.	the d y the iched	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown									
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rds	quires n sign	d by								1,24	s 2□No	3□Pro	bably 4 ☐Unknown
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m	The la	шо								autops perfori	med?/ d	eath?	2 □ No
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r <	nyslc nis ce direc	To E	examiner? 1 Yes 2 No	fospital: 1 Inpa	tient 2 🗆	ER/Outpatier	nt 3□ DOA Oth	ner: 4 □ Nu	ırsing Hom	e 5 Reside	ence 6 □Othe	r (Spec	ify)
0	Attending Physician: r death. ector: After this certific by the funeral director,	Ë.	27. Manner of Death 1.☐Natural 5 ☐ Pending	28a. Date of In (Month, D	jury Jay Year)	28b. Time o Injury	Wo			3d. Describe ho	ow injury occurre	∌d	
Division or Vital Records,	tendi eath. tor: A	catio	2 Accident investigation 3 Suicide 6 Could not be					Yes 2□					V6 to No.
Ë	or At after d Direct in by	Certification:	4 Homicide determined	28e. Place of it building,	njury - At ho etc. <i>(Specif</i>	ome, farm, str fy)	eet, factory, office		28	3f. Location (Si City or Town		r or Hur	ral Route Number,
	ospital hours a uneral I		29a. Certifier + Certifying Phy	sician: To the bes	at of my kno	wledge deat	h occurred at the t	ime date ar	nd nlace a	nd due to the c	ause(s) and ma	nner as	stated.
	the Hospital hin 24 hours a the Funeral mpletely filled	Medical	(Check only 2 Medical Exam)		of examina								
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Me	29b. Signature and title of certifier				29c. Licens	se number		2	9d. Date signed	(Month	, Day, Year)
	->-0		X Mccelu	7			1040	124	>	1	Zebruc	24	4.7008
			30. Name and address of person who co	ompleted cause of	death (Iten	n 23a) (Type,	Print)	V (-			201-6		., - 4
	6		-TUCOCK IV VW	2 1120	No	Kelin	Rd Co	tersi	114	w	2125	8	4,7008
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chard G. Lambe		State of Maryland / Department or Certificate or	f Health and Mental H	ygiene	3000 0310
Dhariaia	Re	equistrar Decedent's Name (First, Middle,Last)	Death	Reg 2. Date of Death	3. Time of Death
Physiciaı Examinاد '''≺م		Richard G. Lambert, Jr.		Month [February 1,	2008 Year 0605 hrs
	4	a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deatl Cheltenham	n	4c. County of Death Prince George's
		10404 Angora Drive Social Security Number 16 Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hr	s. 8. Date of Birth	(MM/DD/YYYY) 9. Birthplace (State or
Funeral Director		3. Social Security Number	Months Days Hours Mir	_	Foreign M 1
Bircotor		214-82-2555 1X M 2 F 46 Yr		111481	
any	1	10a. State 10b. County 10c. City, Town or Loca	tion		10d. Inside City Limits 1 Yes 2 X No
varyland 28a-f show any <u>d at once,</u>		Maryland Prince Georges Cheltenham	10f. Zip Code	110	g. Citizen of What Country?
th the Maryland 23a or 28a-f sho notified at once.	ě۱	10e. Street and Number	20623		US A
ith the		10404 Angora Dr. 11. Marital Status 12. Was Decedent Ever in U.S. 13. W	as Decedent of Hispanic Origin? (\$	Specify Yes or No-	14. Race - American Indian, Black,
eath w		1 Never Married 2 X Married Armed Forces? If	Yes, specify Cuban, Mexican, Puerl	o Rican, etc.)	White, etc.
after dal", or	by F	3 Widowed 4 Divorced If Yes, Give Year 84-88 1	Yes 2 X No specify:	Fundadana	Specify: White 16b. Kind of Business/Industry
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36 in 72 s. than "	Bet	Elamentary ()	ician		Pest Control
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D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once		Richard G. Lambert, Sr.			ber, City or Town, State, Zip Code)
MD 2' Id 2 should lith and M m 27 is m;	-1		4 Angora Dr. Che		MD 20623
e, M and 2 Health item 2 traum		20a. Method of Disposition 20b. Place of Disposition	osition (Name of cemetery,	Date	20c. Location - City or Town, State
nor ages 1 ant of 1	_	1 XX Burial 2 Cremation 3 Removal from State Meadowbr	anch Cemetery 2-	-8-2008	Westminister, MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items injury or other traumatite event, the Medical Examiner must be:		21 St. Ur. of Full Lor e Licensee	Name and Address of Facility	ee Funera	Home Inc. Rd. Clinton, MD 20735
		22. Part I. Enter the disease, or complications that caused the death. Do not enter	the mode of dying, such as cardiac	or respiratory arre	est, shock, or heart Approximate Interval
Physician Medical	1	failure. List only one cause on each line.			
∡aminer		Immediate Cause (Final disease or condition resulting in death) a. Gastron resulting in death) Due to (or as a consequence of):			
		Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):			
	nine	Cause. Enter Underlying Cause			
k ^B isi	Examine	events resulting in death) Last Due to (or as a consequence of):			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trait	ical	UNPENDED AMENDED			
'60, ate be physici	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy	0 TEstavia 200		23d. Date of delivery Month Day Year
Box 68760 e death certificate be the attending physical for use as the bu	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Pregnant at time of death 5	Fetal death 3 Ectopic pre-	griancy	World
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.O. that the ed by	by PI	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	1 Ye	
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/ital /sician uis cert directo	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	ent 3 DOA Other Nu	rsing Home 5	Residence 6 Other: Scene
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ttendii death. rtor: /	atio	1 Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, s		28f Location	(Street and Number or Rural Route Number, City
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Division of Vital Records, To the Hospital or Attending Physician: The law required within 24 hours after death. To the Funeral Director: After this certificate has been to completely filled in by the funeral director, page 2 should		29a Certifier	ccurred at the time, date and place,	and due to the cau	use(s) and manner as stated.
To the F within 24 To the F complete	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	igation, in my opinion, death occurr	ed at the time, date	e and place, and due to the cause(s)
F. 2 5 8	≊	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year) February 1, 2008
		Carol Hallain	O.C.M.E.		1 oblidary 1, 2000
13x1		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Per	nn Street, Baltimore, MD 2	1201	
	tate	31 Pate filed (Month, Cou Voor) 32 Registrar's Signature			
Regis		0 0 0000 Zdw - All Alle	ull)		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #8 Per FH G876 2/08/08 III Certificate of Death Reg. No. 1 - For State Registrat Reg. No 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1730 M Delano OY 21 /Medical P 0,0 4c. County of Death 4a. Facility Name (a not institution, give street and number) 4b. City, Town, or Location of Death Bouth More VLCI

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

5-20-1954 Examiner 井302 1401 Street Dliver Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 217646073 Mid. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 □ No Baltimore MD Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21213 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Electrician 17. Father's Name (First, Middle, Last) Unk 18. Mother's Name (First, Middle, Maiden Surname) UNI Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son Batto Md. 21215 Avenue yrone 20a. Method of Disposition
1 ☐ Burial 2 D Cremation 3 ☐ R
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3 Removal from State :08 cto Md. reenmount 22. Name and Address of Facility Services

5151 Baltimore, Mationa 21. Signature of Funeral Service License Balto Mal aug 21229 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 12/2/2007 whowship /Medical Due to (or as a consequence Examiner Uzino Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): HPIOR attending physician and Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate Discis 1□ Yes 2√No 40000 Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No ၉ this within 24 hours after usa....

To the Funeral Director: After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1'Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) a, w Ci Ererice ST 21201 BEN K. UI 32 Strar's Signature 31. Date filed (Month, Day) Year)

DHMH 17 Rev 1/2001

State Registrar

2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #8, perFH, C876, 2/6/08 TT Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Allen Lewis Jr. 03:40 aM Jabuary 30 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death Sinai Hospital of Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 8/21/1928 9. Birthplace (State or Foreign (Month, Day, Year) NC 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2□F Director 81 241-06-0926 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 10d. Inside City Limits Director 1 TYYes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 5432 Price Ave 21215 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. and 2 should be filed within 72 hours after ealth and Mental Hygiene. 1X Never Married 2 Married EW15 21215-0036 1 ☐ Yes 2 🕱 No Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed). 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) the 6th grade Disabled Disabled Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Allen Lewis Sr. Hattie Whittaker ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 63 t of Health a Margaret Elbeck-Sister
20a. Method of Disposition 5432 Price Ave, Baltimore, Md 21215 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Memorial Park 2/4/08 Randallstown, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 Part 1. Enter the visease, or complications that cause of shick, or heart filure. List only one cause on each line eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **hysician** Sepsis Medical Due to (as a consequence of): Examiner tract Injection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Unnayy Due to (or as a or sequence of) Examine physician and is the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical ast IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify). 1 Yes 2 No the 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2□ No 24a. Was an phicle injection autopsy performed 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation Intury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or To the Hospital within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000. January Margina 30,2008. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital of Bultimore Sinai 31. Date filed (Month, Day, Yeat 62. Registrar's Signature State

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Wilhelm H. Martens February 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Rehab Nursing E Frederick Golden Living If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1**X**M 2□F September 14, 1909 98 Germany 052-09-3937 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event than "natural". 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 Yes 2 No Director Pennsylvania Adams Fairfield 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code USA. 17320 200 Wilderness Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: altimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Transportation Railroad Engineer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gerhardine Garrels Martens <u>Anna</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Fairfield : PA 17320 200 Wilderness Lane William Martens 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Hanover, MD February 6,2008 Ardent Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ardent Cremation Services Laura Christine Hardesty 7522 Connelley Drive Suite N. Hanover, MD 21076 M01197 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Chronic Dementia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the leading to immediate the leading to impediate the leading to the leading that initiated events resulting in death) Last Due to (or as a consequence of): Examine been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 1 □ Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an Leucocy tosis has autopsy performed Yes 2 Thrombocytosis Hospital or Attending Physician: 26. Place of Death (Check only one) director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 28a. Date of Injury (Month, Day Year) filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 24 hours after death. e Funeral Director: After Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hor To the Fune 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mD. 108 D54636 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syed Haque . M.D. Montclair Avenue Frederick, MD 700

Registrar

State

31. Date filed (Month, Day, Year)

FEB 06

2008

32. Registrar's Signature

Physic /Medi Exami

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

•	1- For State Registrar Certifica	ite of Death	Reg. No.								
	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day	3. Time of Death							
an :al	wannie Gione neniiiion, 51.		February Day								
er		y, Town, or Location of Death		Anne Arundel							
	, 52, 2001.0) 1142.02 00-20	asadena der 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign							
	214-38-0265 ¹ Mm ² F 66 Yrs. Month	s Days Hours Min.	06/29/19	41 Country) WV							
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits							
ö				1 ☐ Yes 2 🗹 No							
rect	10e. Street and Number	Zip Code	10g. Citi	izen of What Country?							
١٥	7629 Stoney Harbor Court	21122	U.	.S.A.							
nera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	cedent of Hispanic Origin? (Sp pecify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian, Black, White, etc.							
Completed by Funeral Director	Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 No 1959 - 1 Yes 3 Widowed 4 Divorced Year or Dates: 1969	2 No Specify:	Tricari, etc.)	Specify: White							
eted	15. Decedent's Education 16a. Decedent's U (Specify only highest grade completed) (Give kind of life. DO NOT	kina	ind of Business/Industry								
E	Elementary/Secondary (0-12) College (1-4or 5+) Fire	Fighter	AIII	County							
ပိ	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden								
To Be	Wannie Clone McMillion, Sr.	Marga	ret Johnso	on							
-		ess (Street and Number or Ru	ral Route Number, City o	or Town, State, Zip Code)							
	Sharon McMillion/Wife 7629 St	oney Harbor (Court, Pas	adena, MD 21122							
	20a. Method of Disposition 20b. Place of Disposition (Incremetery, crematory)	lame of prother place)	Date 20c. Lo	ocation - City or Town, State							
	1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MD Veteran		06/08 Cro	ownsville, MD							
		and Address of Facility G Riviera Driv		Funeral Home, PA							
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the n shock, or heart failure. List only one pause on each line.			Approximate Interval Between							
	Immediate Cause (Final disease or condition	4 601	11202	Onset and Death							
	resulting in death) a. e to (or as a consequence of):	resulting in death)									
Ι,	Sequentially list conditions. b.										
ine	Sequentially list conditions, if any, leading to firm and the cause. Enter Underlying Cause (Disease or injury that initiated events b. The to (or as a consequence of): cause (Disease or injury that initiated events)	1m									
Medical Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):										
a E											
edic	0.										
M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopi	c pregnancy		23d. Date of delivery							
Completed by Physician/N	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			Month Day Year							
F.	Part II. Other significant conditions contributing to death but not resulting in the underlyin	g cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?							
d by	COCOIDC DOUNTHONIO		Yes 2	2□ No 3□ Probably 4□Unknown							
olete			24a. Was an	24b. Were autopsy findings available prior to completion of cause of							
mo du			autopsy performed? 1∐ Yes 2 X No	death?							
Be C		26. Place of Dea	ath (Check only one)								
To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other: 4 Nursing H	ome 5. Residence	6 □Other (Specify)							
Ë	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how inju	iry occurred							
catic	2 Accident investigation M 3 Suicide 6 Could not be 28e Place of injury - 4t home farm street fac	1 Yes 2 No	00/ 1	and Alicenter on Provide Alicenters							
ertifi	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, fact building, etc. (Specify)	тогу, опісе	City or Town, State	nd Number or Rural Route Number, te)							
Medical Certification:	29a. Certifier Check on American Servician: To the best of my knowledge, death occur (Check on American Examiner: On the basis of examination and/or investigation and manner stated.	red at the time, date and place tion, in my opinion, death occu	e, and due to the cause(s urred at the time, date an	s) and manner as stated. nd place, and due to the cause(s)							
Mec	29b. Signature and file of centier	29c. License number	29d. Da	ate signed (Month, Day, Year)							
	X/X/	020787	2 03	101/2008							
	30. Name and address pregron who completed cause of death (Item 23a) (Type, Print)	1/65/30		1011200							
	\$TEPHAN ABI MO.	575 PMG	UTE HXWDL	SCRULIVED FOR							
ate rar	0 C 2008 Milestote & All	D	(1)	revovo							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 6:30 PM M Audrey A. McGrath 01 30 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Oak Crest Care Center Parkville, Maryland
If Under 1 Year | If Under 24 Hrs. | 8 Da Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 12/26/1923 7. Age (In vrs. last birthday) **Funeral** Days Min. Hours 1 □ M 2 🗙 F Director 212-20-8373 84 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location iral", or Items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 U.S.A. 8800 Walther Blvd. - Apt. 3315 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married "natural", or 1 ☐ Yes 2 X No δ Specify 3 XWidowed 4 ☐ Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home other Maryland 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be eafth and Mental S. George Zimmerer Mary Ullrich 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If Item 27 Is any Injury or other trau 60 <u>Patrick J. McGrath, Jr.</u> (son) 2931 Edgewood Avenue - Baltimore, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 Date 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State 4☐Donation 5 ☐ Other (Specify) 02/04/2008 Baltimore, Maryland Parkwood Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. avaak 11750 Belair Road - Kingsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respirator **Physician** /Medical Due to (or as a consequence of) Examiner ellmone Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): the burial-68760 as IF FEMALE: use 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) detached Ö the 9☐Unknown 9 Unknown signed by ٦. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, page 2 should be 2 No 3 Probably 4 Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an The or Vital 1□ Yes 2 No Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No after death filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed Walter Blod raven 31. Date filed (Month, Day, Year) State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 08:11 AM Elizabeth S. McCall 04 2006 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 3, 1932 9. Birthplace (State or Foreign 5. Social Security Number Hours 1 □ M 2 🔀 F 76 219 28 6625 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Maryland Baltimore Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21221 USA 1010 North Avenue 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Medical Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Foster Joseph McCall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2228 Coralthorn Rd. Baltimore, Maryland 21221 Linda Ford (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gardens 2/8/2008 Bel Air, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 21. Signature of Funeral Service Licensee 23a rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Linknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an nerformed? 2□No 25. Was case referred to medical examinar?
1 ☐ Yes 2 ☐ No 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

be executed attending physician and for use as the burial-trar P.O. signed by the a Division or Vital Records, peen has page certificate funeral director, After this

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

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"natural".

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Baltimore,

Department of Health a Important: If Item 27 is any Injury or other trau

Physician /Medical Examiner

the Medical

Director

Funeral

Completed by

Be

Examiner

Physician/Medical

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Completed

Be

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Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 ☐ Unknown

27. Manner of Death 1 Natural

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury 28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Tyr.e, Print)

Assoc Chair

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

29d. Date signed (*Month*, *Day*, *Year*)

31. Date filed (Month, Day, Registrar

Goodsaman tan Hospital 5601 Loch Raven Blud Bultimuse 21289

To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director; After it completely filled in by the funeral

			for State Registrar	State of Mar		ertificate of			giene Reg. No. 2001	8 03200
	Physici	an	Decedent's Name (First, Middle, NAP, TOP, T.P., T)	•				2. Date of De Month	ath Day 2008	3. Time of Death
	/Medic	al	MARJORIE L. M 4a. Facility Name (If not institution,			4b. City, Town, c	or Location of Death		4c. County of De	
100	Funeral Director	eı	Morningside of 5. Social Security Number 273-14-1596	Dorsey Hall	(In yrs. last birthda) Yrs.	Ellicot	t City	8. Date of Birt	Howar	
	/land ow at		Usual Residence of Decedent 10a. State 10b. County	1	10c. City, Town or I	ocation				10d. Inside City Limits
	e Man, ia-f sh tified	ctor	MD Howa	ard	Woodst	ock				1 □Yes 2√ No
	vith the	Director	10e. Street and Number	. 101		10f. Zip Code			10g. Citizen of What 0	Country?
	leath v	Funeral	2130 Ganton Gre	-	er in U.S. 13		163	acity Ves or No.	USA - 14. Race - Am	nerican Indian
9036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Heatth and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 □ Never Married 2 X Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? ed 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates;		. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 X No	an, Mexican, Puerto Specify:	Rican, etc.)	Black, Wh	
Maryland 21215-0036	vithin 72 h ine. han "natu ie Medical	Completed	15. Decedent' (Specify only highes: Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Giv	edent's Usual Occup e kind of work done DO NOT use retired	during most of worl d)	king	16b. Kind of Busines	
0 0	filed wi Hygien other th ent, the	Be Co	17. Father's Name (First, Middle, L	ast)		Homemaker		ie (First, Middle,	Own I Maiden Surname)	lome
/lan	2 should be filed v o and Mental Hygie is marked other t raumatic event, th	To B	John Miketo				Mary	Soltis	,	
Mar)	12 sho h and l is ma rauma		19a. Informant's Name/Relationsh		19b. Mai	ing Address (Street	and Number or Ru	ral Route Numbe	er, City or Town, State,	. Zip Code)
ē,	tem 27		Pamela L. West 20a. Method of Disposition	(Daughter)	213 20b. Place of Disp	O Ganton osition (Name of ematory or other place	Green Ap	t.101, W	Voodstock, 20c. Location - City of	
ē	Pages nent of I int: If ite		1 X Buria! 2 □ Cremation 4 □ Donation 5 □ Other (<i>Sp</i>			ematory or other plac 'ark Nat'l		/08	Baltimore,	
Baltimore,	ermit. Pages 1 an epartment of Heal mportant: If item 2 ny injury or other once.		21. Signature of Funeral Service L	2 D		22. Name and Addre	ss of Facility		<u> </u>	
9			23a. Part1. Enter the disease, or or shock, or or failure. List of	complications that caused the	ne death. Do not ei	250 Washi nter the mode of dyir	ncton BL ng, such as cardiac	or respiratory ar	ridce, MD	21075 Approximate Interval Between
, e	Physician		Immediate Calle (Final disease or condition resulting in death)	_a Alteros	clerotic	Cardio ny Disc emente	Vascula	W DU	scape	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c	consequence of):	DIK	ear			
	3 .	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a c	consequence of):	7				
V	ecuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last			emente	ř			
68760,	ificate be executed g physician and as the burial-transit	Sal Ex	resulting in death) Last	Due to (or as a c	consequence of):					
_		Medical	IE ECNALE.	a.		4.5				
O. Box	The law requires that the death certificate has been signed by the attending age 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf 1□Live birth 2 4□Pregnant at tin 9□Unknown	☐ Fetal death 3	□Ectopic pregnancy □ Other (specify) _	/		23d. Date of d Month	elivery Day Year
ds, P.	w requires that the d been signed by the should be detached	5	Part II. Other significant condition	ns contributing to death but r	not resulting in the	underlying cause giv	en in Part I.	23e. Did to		to the cause of death?
SCOL	aw req s been 2 shoul	lete						24a. Was		autopsy findings available
Vital Records,		Completed						autop perfo 1∐ Yes	prior to prior to death? 2 No 1 □ Ye	completion of cause of
	/siciar s certif	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	2 ☐ ER/Outpatie	nt 3 DOA Oth	er:		ne) lence 6 Other (Sp	ASCE TO LIVE
o u	ng Phy fter thii neral o	\vdash	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury	28b. Time				now injury occurred	ecity) /1330) Car Civily
UIVISION	teath. tor: Ai the fu	catic	2 Accident investiga	tion at he		M 1 🗆	Yes 2 □ No			
<u> </u>	al or At after d I Direc d in by	Certification:	4 Homicide determin			reet, factory, office		28f. Location (S City or Tow	Street and Number or F vn, State)	Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific: completely filled in by the funeral director,	ca	Check only 2 Medical E	Physician: To the best of r xaminer: On the basis of ex and manner state	xamination and/or i	າvestigation. in mv ດ	pinion, death occur	rred at the time	date and place, and di-	ie to the cause(s)
	To th Withir Comp	Ĭ	29b. Signature and title of certifier	0 .		29c. Licens	e number		29d. Date signed (Mor	nth, Day, Year)
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	5		29b. Signature and title of certifier 29b. Signature and title of certifier 8 30. Name and address of person w 8 6 6 7 8 8 8 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	no completed cause of deat	th (Item 23a) (Type	River N	leck Ro	ad Ro	1/1 more	Mary kind 2/22
	Sta Registra	e ir	31. Date filed (Month, Day, Year)	2.003 32. Régistrar's	s Signature	port				,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 8.55 PM 10rris 2008 /Medical Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** Hospita Memorial Social Security Number 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months 1□M 2**X**]F Hours Min. Director Usual Residence of Decede death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 □ Yes 2 □ No Completed by Funeral Director timore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Was Decedent Ever in Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life_DO NOT use retired) al Hygiene. ondary (0-12) College (1-4or 5+) Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental H 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 20a Method of Disposition Burial 2 Cremation 3 R Wings Mills, e of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dvi shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 24 hrs. Preumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): 24 hrs. Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy rate has been signed by the atte page 2 should be detached for in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 □ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an autonsy perform certificate To the Hospital or Attending Physician: the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) after death. I Director: After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar MD

Nazi Farsi

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201 E. University PKWY

32 Registrar's Signature

DHMH 17 Rev 1/2001

AT2438946

Baltimore, M.D 21218

union memorial

Hospita

08-00942 Suzanne McKibbin	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene								
Physician/	1- For State Certificate of Death Reg. No. 2008 US 2008								
Medical Examine	Suzanne McKibbin Suzanne McKibbin Pebruary 2, 2008 1500 hrs								
	4a. Facility Name (if not institution, give street and number) 11450 Little Patuxent Parkway Apt. +620 602 4b. City, Town, or Location of Death Columbia 4c. County of Death Howard								
Funeral Director	5. Social Security Number 214-68-2396 1 M 2X F 53 Yrs. 1. Age (In yrs. last birthday) 1. Months Days Hours Min. 1. Months Days Hours Min. 1. Months Days Hours Min. 2. Age (In yrs. last birthday) 2. Months Days Hours Min. 2. Months Days Hours Min. 3. Date of Birth (MM/DD/YYYY) 3. Birthplace (State or Foreign Country) 4. PA								
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State								
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D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director									
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md 2 steel the steel term 27 traums	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State								
imore Pages I ment of F tant: If i	Burial 2 X Cremation 3 Removal from State Hilltop Service Corp. 2/6/08 Towson, MD								
Balt permit Depart Impor injury	21. Signature of Funefal Service Licens 22. Name and Address of Facility 1050 York Rd., Towson, MD 21204 1050 York Rd., Towson, MD 21204								
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Neck Injury Approximate Interval Between Onset and Death								
xaminer	or condition resulting in death) Due to (or as a consequence of):								
iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause								
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). Box 68760, the death certificate be expy the attending physician ched for use as the burial. Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23d. Date of delivery Month Day Year								
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Division of Vital Records, P.O. B Division of Vital Records, P.O. B and Attending Physician: The law requires that the d trs after death. In Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached errification: To Be Completed by Physician and provided the physician of the completed by Physician and provided the physician of the physician and provided the physician of the physician and provided the physician and provided the physician and physician are provided the physician and physician are provided to the physician and physician are provided to the physician are provi									
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Vital Rechysician: The this certificate diffector, page	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 ✓ Other: Scene								
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Division of Vital Rec Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page									
A P	29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)								
	Thurst Graffiall, MD O.C.M.E. February 3, 2008 30. Name and address of person who completed cause of death (Item 23a)								
B	Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
State Registra	CONTROL DE LA COLLEGE DE LA CO								

08-00942

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 0048AM Harry Meyers-Bey, Jr. 2008 -ebruary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Agnes Hospita BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) MD **Funeral** Hours Days 1₹ M 2∏ F 65 217-70-6312 Director Oct. 1, 1942 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1⊈Yes 2 No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21229 USA 3723 Edmondson Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married African American 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Markin Injury or other traumatic event, the Markin n/a n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Meyers-Bey, Sr. Alma Smith ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3723 Edmondson Avenue; Baltimore, Maryland 21229 19a. Informant's Name/Relationship (Type. Print) Alma Smith / Mother Date Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 12 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Woodlawn Cenwtery 02/07/2008 Woodlawn, Maryland 21. Signature of Funeral Service Licent 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland عالم Ones 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Celluli nours **Physician** eg /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown been signed by to should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a. Was an page 2 autoosy perform 212No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident ould not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Records, P.O. **Division or Vital** Attending Hospital or

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

burial-transit

attending physician for use as the buria

the detached

certificate

After this

and

certificate be executed

Box

State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

FEB 0 6 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.



D.0.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03204 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** MYER S JANET 1430 M FEBRUARY 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital Baltimore City If Under 1 Year | If Under 24 Hr Months | Days | Hours | Mir 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) July 15, 1962 9. Birthplace (State or Foreign **Funeral** 1 M 2 TF Country) MD 218-92-8931 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Baltimore 1 ☑ Yes 2 ☐ No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21202 USA 925 Saint Paul Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: þ Specify: 3 Widowed 4 Divorced Black. Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nurse private nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret White Reginald Myers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6102 Marguette Road; Baltimore, Maryland 21206 Carolyn Harvin / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ₭ Burial 2 Cremation 3 Removal from State 02/05/2008 King Memorial Park Randallstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** FULMINANT LIVER FAILURG 2 weeks /Medical Due to (or as a consequence of): Examiner SEPSIS 1 Month Sequentially list conditions, Due to for as a consequence of Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hepatitis C 10 years attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, 15 years HIV IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hepatitis B 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Hepatitis D 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ibironke Oduyeba Medical Doctor Res-000 February 2, 2008

State Registrar

31. Date filed (Month, Day, Year)

FEB 0 6 2008

DHMH 17 Rev 1/2001

Ibironke Oduyebo, The Johns Hopkins Hospital Goo North Wolfe Street, Ballimore, Mayundalost

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22. Registrar's Signature

			State of Maryland / Dep State of Maryland / Dep Registrar Ce	artment of Health and N rtificate of Death		ene No.2008 03205
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year
	/Medic	al	John William Neil	4b. City, Town, or Location of Death	February	4, 2008 1:55 PM
	Examir	ier	4a. Facility Name (If not institution, give street and number) 303 Leeanne Rd.	Essex		Baltimore
24-	Funeral	Ø.	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	9. Birthplace (State or Foreign Country)
, made	Director	0	216 30 5604 123.M 2 F 74 Yrs.		Feb. 9, 19	33 Maryland
	laryland show		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	a-f sh	ctor	Maryland Baltimore Esse	ex.		1 □Yes 2XNo
	h with the 23a or 28 st be no	al Director	10e. Street and Number 303 Leeanne Rd.	10f. Zip Code 21221	10g	. Citizen of What Country? USA
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 □ No If Yes, Give Year or Dates: 53-5L	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	filed within 72 ho Hygiene. ther than "natur ent, the Medical i	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) Cison Guard	ring	Exist of Business/Industry Prison
d 2	illed Hygi other ent, t	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Ma	iden Surname)
/lar	2 should be filed w n and Mental Hygie is marked other t raumatic event, th	To B	Philip James Neil	Helen	Deickman	
Maryland	12 sho			ing Address (<i>Street and Number or Rui</i> 5 Pine y Hill Rd. M		
	Health Health Iem 27 Other tra		20a Method of Disposition 20b. Place of Disp	osition (Name of	-	lc. Location - City or Town, State
ē	Pages nent of I int: if ite		1 ABurial 2 I ICremation 3 I IRemoval from State 1	matory or other place) 1 Cemetery 2/9/2	008	Baltimore, Maryland
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.			2. Name and Address of Facility Bruzdzinski Funera 407 Old Fastern Av		A. ex, Maryland 21221
	Total I		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			t, Approximate Interval Between
W.	Physician	Ĥ	Immediate Cause (Final disease or condition a. PROSTATE	arcinoma		Onset and Death
1	/Medical Examiner	П	resulting in death) Due to (or as a consequence of):	11 %		
		je.	Sequentially list conditions, if any hadry in a class cause. Enter Underlying Cause (Disease or injury			
	cuted nd nd ransit	Examiner	triat initiated events			
8760,	cate be executed oblysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):			
687	icate t physic	dical	d			
P.O. Box (The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
	w requires that been signed b should be deta	by	Part II. Offer significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba 1 □ Yes	cco use contribute to the cause of death? 2 □ No 3 □ Probably 4 ☑ Onknown
Vital Records,	The law requate has been page 2 should	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? □ No □ □ No □ □ No
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		h (Check only one)	
or	this al dil	은	1		ome 5 X Residen	ce 6 Other (Specify)
O	Attending Ph r death. ector: After th by the funeral	tion	1 X Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	200. 2000	,, 00001100
Division	i i i i i	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical	29a. Certifier (Check or) one) 1 ★ CertifyIng Physician: To the best of my knowledge, dea 2 ★ Medical Examiner: On the basis of examination and/or and manner stated.			
	To t withi	M	29b. Signafyle and title of Certifier August 1990 1990 1990 1990 1990 1990 1990 199	29c. License number	7	d. Date signed (Month, Day, Year)
	10%		30 Marge and address is person who completed cause of death (Item 259) (Type	E108 2006 4	Ad 212	237
-	Sta Registi		31. Date filed (Month, Day, Year) 2008 3 Registrar's Signature			(

			For State Registrar	State of I	Marylan		rtment of H tificate of L		l Mental Hy	giene 2 0	08	03	206
ì	Physici	an	Decedent's Name (First, Middle	e, Last)	694.				2. Date of De	eath	.08	3. Time of	
	/Medic	cal	4a. Facility Name (If not institution			BETH PA	ATTERSON 4b. City, Town, or	Location of De		4c. County		2 •	45ам
į.	Examin	ier	GREATER BALTI			TER	TOWSON	Essensi of Bo		BALTIM			
Ī	Funeral		5. Social Security Number	6. Sex 7. 1 ☐ M 2 ☑ F	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	in. (Month, Da	ay, Year)	Coun		
h.	Director		220-72-3969 Usual Residence of Decedent		61				Oct.1	6,1946		don,En	
	larylan show ed at	ř	10a. State 10b. County	imore	1	,Town or Loc nneslie					1	0d. Inside C 1 ☐ Yes	ity Limits
	the M	Director	MD Balt 10e. Street and Number	Inore	AI	mesite	10f. Zip Code			10g. Citizen of V	Vhat Cour		
	death with the Maryland ms 23a or 28a-f show rmust be notified at		522	Anneslie Ro	ad			21212	1	USA			
	items items ner mi	Funeral	11. Marital Status 1 □ Never Married 2 X Marr	12. Was Decede	s?	S. 13. V	las Decedent of Hi Yes, specify Cuba	ispanic Origin? ın, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	14. Rac Blac	e - Americ k, White,		
USP C	hours after tural", or ite al Examine	þ	3 ☐ Widowed 4 ☐ Divorced	I If Yes, Give⁴	s:	1	☐ Yes 🎎 No	Specify:		Specify	wh	ite	
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717	o filed within 72 h Hygiene Other than "natuent, the Medica	ошо	Elementary/Secondary (0-12)	College (1-4-	or 5+)	me. D	bilingua	_	etary	Wor	ld B	ank	
and	be filed within 72 hours after death with the Marylar tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	BeC	17. Father's Name (First, Middle,	•					lame (First, Middle		,		
5		٥	19a. Informant's Name/Relations	Frederic	k Gil	T	Address (Street	and Number or	Rural Route Numb	Ethel In			
M	th it		Theodore Patte		and		•		Baltimor			Codo,	
ore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		20a. Method of Disposition 1 Burial 2 Cremation		20b. P	lace of Dispos emetery, crem	sition (Name of natory or other place	re)	Date	20c. Location -	City or To		
Бапттог	it. Pagintment intant: injury o		4 Donation 5 Other (5 21. Signature of Funeral Service	Specify)	Gre		nt Cremat		,7,2008	Baltimo	re,	MD	
g	Depa Impo any i	l d	21. Signature of Funeral Service	The Add TV,	re _e	M	tchell-W	iedefe:	ld Funera Baltimore	1 Home, I	nc.		
			23a Part1. Enter the disease, or shock, or heart failure. List	r complications that caust only one cause on each	sed the death	n. Do not ente	er the mode of dyin	g, such as card	diac or respiratory	arrest,	.1.2.	Approxima Interval Be	etween
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a. Car	dior	nyo	sathy					Onset and	Death
	/Medical Examiner		roodiang in dodairy	Due to (or CEV	e lonsequ	uence 1):	unlar	acc	ider	T			
	B =	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0	as a consequ								
/	ecuter and I-trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequ	uence of):							
8/60,	icate be executed physician and s the burial-transit	dical E		d.									
٥	the death certificate be executed y the attending physician and iched for use as the burial-transit	Medi	IF FEMALE:										
X Q Q	feath certific attending p I for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months?		me pf pregna n 2□Feta t at time of d	I death 3□	Ectopic pregnancy	,		l l	te of delive onth	ery Day	Year
<u>.</u>	w requires that the di been signed by the should be detached	hysid	1 □ Yes 2 ☑ No 9 □ Unknown	9□Unknow		ou o_	Carlot (specify)						
<u>ທ</u>	requires that een signed b nould be deta	by P	Part II. Other significant conditi	ons contributing to deat	h but not resu	ulting in the un	derlying cause giv	en in Part I.		tobacco use con		he cause of bably 4	
ecords	requii	eted											
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VItal		Be C	25. Was case referred to medica examiner?					26. Place of I	1□ Yes Death (Check only		1 162	219110	
o_ 	Physic this ce al dire	ပ္	1 ☐ Yes 2 ☐ No			ER/Outpatien		4 LI Nursin	g Home 5 □ Res	idence 6 Oth		fy)	
000	Attending Physician: r death. ector: After this certification of the funeral director, it	tion:	27. Manne of Death 1 Natural 5 Pendii 2 Accident investi	28a. Date of (Month, gation	Day Year)	Injury	28c. Injur Wor M 1 🗆	yai k? Yes 2∐No	Zed. Describe	now injury occur	red		
DIVISION	or Atter ifter deal Director in by the	Certification:	3 Suicide 6 Could 4 Homicide determ	ninod Zoe. Place of	injury - At ho , etc. <i>(Specif</i>	ome, farm, stre	eet, factory, office			(Street and Numi own, State)	er or Run	al Route Nu	mber,
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	edical Ce		ng Physician: To the be Examiner: On the bas and manne	s of examina								(s)
	To the within To the comple	Me	29b. Signature and title of certific	er			29c. Licens		. —	29d. Date signe			
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	le		CVPITE	, and MI	> 670	1 N.C	hanes	St. Bo	11 timo	re MO	2/2	oy	
	Sta Registi		31. Date filed (Month, Day, Year, FEB 0 6	7.7	istrar's Signa	ture	rek s						
DH	IMH 17 Rev 1/2	-	FEDVO	2000	15.1 15	1	400	-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 31 4:03 PM atherine January 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Johns Hopkins Baltimore Bayview Medical Center 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign 1 □ M 2 🙀 F Months Days Hours Min. Jul 17, 1936 Georgia 216-30-0595 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 1 XYes 2 No Owings Mills Director **Baltimore** Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21160 USA 3410 Associated Way Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Hospital Nurse 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lula Jackson Boysie Bradley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 811 Smoke Tree Road Baltimore, Maryland 21208 Lydia Matthews-Atkins Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ **X**Burial 2 □ Cremation 3 □Removal from State Brooklyn Park, Md. 02/06/08 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery & Mausoleum 22. Name and Address of Facility Funeral Service Licens Estep Brothers Funeral Service, P 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final failure Liver Week disease or condition resulting in death) Due to (or as a consequence of): abdominal Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Right hemicolectom Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4□Pregnant at time of death Yes 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed No autopsy 2□ No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 20 No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident

The law requires that the death certificate be executed and burial-Box 68760, physician the attending phi for use as the P.O. signed by t Division or Vital Records, page 2 should has certificate or Attending Physician: After after death.

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notifled at

"natural".

marked other than

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Department of Health au Important: If Item 27 is any Injury or other trau

Physician

/Medical

Examiner

event, the Medical

hours after

within 72

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ould be f

Pages 1

and

Saltimore, Maryland 21215-0036

Examiner Physician/Medical þ Be Completed Certification: To the filled in by

5 Pending investigation 6 Could not be

28a. Date of Injury (Month, Day Year) 28b. Time of

Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

mor

and manner stated.

RES- 000

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KUH EMERY MD # 4940 EUSH

EB 2008

title of dertifie

3 ☐ Suicide

29a. Certifier

one)

29b. Signature and

Medical

State

Registrar

4 ☐ Homicide

(Check only

Eastern Avenue Baltimore,

24 hours a Hospital

within 24

		Please T	ype or Print in E State of Marylan				•		egible.	
		For State Registrar	otate of marylan		Certificate of I		a mornar rr	Reg. No.	2008	03208
Physic	ian	1. Decedent's Name (First, Middle, Last)					2. Date of D Month		Year	3. Time of Death
Physic /Medi		Mead	Charle	3		er II	[Februa	ry 2	2008	1:54p M
Exami	ner	4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of E		4c. C	ounty of Death	
Funeral Director	*	5. Social Security Number 6. Sex 213-34-0788	7. Age (In yrs.	ast birth		If Under 24	Hrs. 8. Date of B	irth Pay, Year)	Coui	place (State or Foreign htry) M.D.
nh		Usual Residence of Decedent	69				10 1	. 2 3		
arylan show dat	-	10a. State 10b. County			or Location				1	10d. Inside City Limits
the Ma 28a-f	Director	MD NA 10e, Street and Number	Ва	LUL	more			10a Citiza	en of What Cou	
3a or	Ö	3610 Park Height	s Ave			1215		rog. Onize	U.S.A	
death	Funeral		Was Decedent Ever in U. Armed Forces?	S.	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin	? (Specify Yes or N	0- 14	1. Race - Americ Black, White,	
after or ite		1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give No		1 ☐ Yes 3√ No	Specify:	derito i flouri, oto.,			ack
hours tural",	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	16a. I	Decedent's Usual Occup	ation			d of Business/In	
nin 72 In "na Medic	plet	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give kind of work done of life. DO NOT use retired	during most of	f working		or Businessym	
If it is in 2-0050 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Completed	12th grade	na (1-401-34)		Welder			A	mtrak	
d tal	Be	17. Father's Name (First, Middle, Last)					Name (First, Middi Wolfe	e, Maiden S	urname)	
an yid should and Men Is marke	2	Mead Palmer Jr		19b.	Mailing Address (Street			ber. City or	Town State Zir	Code)
Health ar tem 27 is tem 27 is other trau		Alice L. Palmer		1	l Thistle			_		'
ges 1 a t of Hear if item or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	20b. P	lace of I	Disposition (Name of crematory or other place	ce)	Date	1	ation - City or To	
mit. Pages mait. Pages partment of portant: If if		4 Donation 5 Other (Specify)	Ki.	ng	Memorial			Ran	dallst	own, Md
permit. Pages. Department of Important: If ite any injury or ot once.		21. Signature of Funeral Service Ligense	* Aumit		March F/ 4300 Wab	h Wes ash A	t ve, Balt	imor	e, Md	21215
		3a. Pa 1. Enter the disease, or compli- sh ck, or heart failure. List only on						arrest,		Approximate Interval Between Onset and Death
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Examiner			Due to (or as I consequent	ience of	Cardia	NUOD	athe			
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ficate be ex physician a			Due to (or as a consequ	Jence o),					
do/ ficate g phys	edic	d								7271277
death certificate attending pl	Physician/Medical	23b. was decedent pregnant	3c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta		3 □Ectopic pregnancy	,		23	3d. Date of deliv	
e deal	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of d		5 Other (specify)				Month	Day Year
that the ed by the detact		Part II. Other significant conditions con	tributing to death but not resi	ulting in	the underlying cause giv	en in Part I.	23e. Did	tobacco us	e contribute to t	he cause of death?
requires t	d by						1	Yes 2	No 3□ Pro	bably 4 Unknown
Physician: The law requires that the death certificate be this certificate has treen signed by the attending physicial director, age 2 should be detached for use as the burnal director.	ompleted						24a. Wa	s an	24b. Were auto	ppsy findings available
The tree te ha	mo:						— aun pei 1∐ Yes	opsy formed? 2 □ No	prior to co death? 1 ☐ Yes	mpletion of cause of
siclan: The certificate rector, ag	Be C	25. Was case referred to medical examiper?	anaital:	_	Tou.		Death (Check only	one)		
Physi Physi this o	2	1 es 2 No	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outp 28b. Ti		4 LI Nursi	ing Home 5 □ Re 28d. Describ			fy)
tending eath. tor: After the funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)		jury Wor	k? Yes 2∐No		s now injury	occurred	Į.
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - At he building, etc. (Specif	me, fari	m, street, factory, office			(Street and own, State)	Number or Run	al Route Number,
spital o		29a, Certifier 1 Certifying Phys	ician: To the best of my kno	wledge.	death occurred at the ti	me, date and	place, and due to the	e cause(s) a	and manner as	stated.
n 24 hr n 24 hr ne Fur.	Medical		ner: On the basis of examina and manner stated.							
To the within To the comp	Me	29b. Signature and title of certifier	40		29c. Licens				signed (Month,	
1		fatra My	m.D		1000	544	82	Febr	uary o	2,2008
5		30. Name an address of person who co		23a) (1	ype, Print)	, ,	, ,	1	0 11	2,2008 ore, MD21215
-	ate	Patrick McG, 31. Date filed (Month, Day, Year)	n ley M.O. 32. Registrar's Signa	ture	2401 WES	t Be	Wedere	Ave	Daltim	ore, 1411/2/215

DHMH 17 Rev 1/2001

State

Registrar

FEB 0 6 2008

PROVED

Asserte

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 29,2008 January Robinson M. EdWard /Medical 4c. County of Death 4b City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner maxyland General autimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Bate of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Days Months Hours 1XM 2□ F Yrs 07 MD 40 Director 212-80-8823 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 √Yes 2 No Baltimore Director NA MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 U.S.A. 3915 Calloway Ave Apt 503 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 24☐ No If Yes, Give Year or Dates: 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes X ☐ No Specify: Specify: Black ð 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
12th grade College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If iten 27 Is marked other the any Injury or other traumatic event, the I once. Landscape Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sandra Robinson Curtis Robinson Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3915 Calloway Ave Apt 503, Baltimore, ace of Disposition (Name of Date 20c, Location - City or Town, State Sandra Robinson-Mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition M□ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 4 Randallstown, Md King Memorial Park 2/2/08 Si ature of Funeral Service Lipensee 22. Name and Address of Facility
March F/H West 23a. P. nt. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death Imm diate Cause (Final discase or condition sulting in death) **Physician** 205/3 /Medical Que o (or as a conse wence of): HUREUS BACTEREMIA Dueto Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): the burial-P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 Tes 2 □ No 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part IJ. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an has 2 □ No After this certificate Yes Division or Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 10065583 Type Print) SAI M. Entaw St. Sende 407 Balto-, Md-2H0/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -medonald, m.D.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, FEB

Year)

ORIGINAL

32. Aegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene20081 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 29 Year **Physician** 7-458 M ROSE JAN 2008 MELBA /Medical 4b. City, Town, or Location of Death . Facility Name (If not institution, give street and number) 4c. County of Death Examiner 1 NURSING HOME HI MORE Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days Hours Min 1 M 2 KF Yrs. Director death with the Maryland 10a. State 10b. County 10d. fnside City Limits 10c. City, Town or Location or 28a-f ehow a notified at 1 Yes 2 No Director MD timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or iteme 23s or other traumatic event, the Modical Exacutar must be re) en (by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 KNo ff Yes, Give 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) rseis 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame Be and Mental 2 William Atkinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas L: Rose (Huss
20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State Department of important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Services 3000 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** END STAGE HIV monetro /Medical Due to (or as a consequence of): Examiner NCEPHA LOPATHY Corporatially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine ed by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Únknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 Yes 2 1√0 1 ☐ Yes 2 ☐ No To the Hoepital or Attending Physician: within 24 hours after death.

To the Funeral Director; Atter this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitaf: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 20 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. fnjury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: United basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

31. Date filed (Month, Day, Year) 2008 6

Shawn MA

Spepte MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Baltimore, Maryland 21215-0036

Box 68760,

Division of Vital Records, P.O.

D0053150

SANTIAGO RO

FEB ISY 2008 SUITEIIO

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month 7:45 PMM January 30, 2008 Florence Silverman 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Manor Care Potomac Montgomery Potomac 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Hours Days Months 1 □ M 2 1 F 92 MD 01/11/1916 218-30-3354 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2 No Director Middlesex Newton Center MA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 02459-United States 70 Warren St. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No þ Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Hamberger Moses Morris Sr. ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7308 Broxburn Ct. Bethesda, MD 20817-Leigh Tischler/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Feb 1 2008 Beltsville, Maryland 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Hoensee M00382 Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dementia Advanced Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ⋈ No 24a. Was an autopsy performed 1 Yes 2 No 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 🔲 Inpatient 28d. Describe how injury occurred

Physician /Medical Examiner or Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

iral", or Items 23a or 28a-f show Examiner must be notified at

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or then any injury or other traumath.

Baltimore, Maryland 21215-0036

burial-transit attending physician an the signed by this

in by the funeral director, Certification: To : After t To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death.

Division or Vital Records, P.O. Box 68760.

25.	Was case referred to medic
	examiner?
	1 Yes 2 No
27	Manner of Death

5 Pending investigation

28a. Date of Injury 28b. Time of (Month, Day Year)

28c. Injury at Work?

2 Accident	
3 Suicide	6
4 Homicide	

1 Natural

29a, Certifier

Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

6

29c. License number D0054566 29d. Date signed (Month, Day, Year) 08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Avenus suih 1-17 9801 GROTIGIA Sunitha Bhogavilli 31. Date filed (Month, Day, Year) 32. Registrar's Signatur

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

completely filled

Medical

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumafte event, the Medical Examiner must be notified at ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

10a. State

Directo

Funeral

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Completed

Be

MD

Funeral

Director

Physi /Med Exam

> the attending physician and has been signed by

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate

Division or Vital Records, P.O. Box 68760,

D State Registrar

19a. Informant's Name/Relationship (Type. P	19a. Informant's Name/Relationship (Type. Print)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
Jeanne Scheno/Wi	.fe	13800	Baldwin	n Mill	Rd.	Balo	lwin,	MD 21013		
20a. Method of Disposition 1 ☐ Burial 2 ☐ Fremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)		ace of Disposition (formetery, crematory of Sapeake	lame of or other place)	Da	ite	20c. Loc	ation - City or T	Town, State		
21. Signature of Funeral Service Licensee	thomas	22. Name P . A .	and Address of Fa	cility CAF	A/Ste astu	epher es I	n D. L Orive	ohrmann, Balto.,N		
23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car Immediate Cause (Final	use on each line.		,	as cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death		
disease or condition resulting in death) a. Due to (or as a consequence of :										
Sequentially list conditions, if any, leading to immediate cause. Clause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ									
that initiated events resulting in death) Last c	Due to (or as a consequ	ence of):								
in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Mo						e contribute to	Day Year			
millifle my				24a. Was auto perfi 1 Yes	psy ormed?	prior to c death?	topsy findings availa completion of cause of			
25. Was case referred to medical examiner?	26. Place of Death (Check only one)									
1 ☐ Yes V2 ☐ No Hospit	al: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient 3□	DOA Other: 4	Nursing Hom	e 5□Res	idence 6	☐Other (Spec	ify)		
	(Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2	28	3d. Describe	how injury	occurred			
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 228	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At he building, etc. (Specification)				Bf. Location (City or To	on (Street and Number or Rural Route Number, r Town, State)				
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due and manner stated.							stated. to the cause(s)			
29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. Certifying Physician 2 Medical Examiner:		29c. License number			29d. Date signed (Month, Day, Year)					
1 Dans 50	David 5D			295		Fel	un	47005		
30. Name and address of person who comple DR. DAVID DUNN - 615	,		RFT ATR	MD 210	1 /1			,		

31. Date filed (Month, Day, Year)

FEB 06

2008

ESSAL!

32. Begistrar's Signature

ENGLASS.

Physicia /Medic Examin

Funeral Director

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	•	or Print in Black Indel e of Maryland / Departr		II Copies Are Legible.			
	1 - State Registrar		icate of Death	Reg. No. 2008 032	13		
n	1. Decedent's Name (First, Middle, Last) Edward Slezak			2. Date of Death Month Pay 1, 2008 9:25 P	th M		
il F	4a. Facility Name (If not institution, give street an	d number) 4b	. City, Town, or Location of Death	4c. County of Death			
141	Stella Maris Hospice		Timonium	Baltimore			
	5. Social Security Number 6. Sex 125 M 2		Under 1 Year If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth (Month, Day, Year) Oct.14,1934 9. Birthplace (State or For Country) West Virginia	-		
_	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location		10d. Inside City Lin			
CTO	Maryland Baltimore	Middle R		1 □ Yes 2 X	11/0		
DIE	10e. Street and Number 1436 Shore Rd.	1	0f. Zip Code 21220	10g. Citizen of What Country? USA			
runera	11. Marital Status 12. Was Arms	Yes 2 □ No	Decedent of Hispanic Origin? (Sps., specify Cuban, Mexican, Puerto				
og pa	3 ☐ Widowed 4 ☐ Divorced If Year	s, Give 1957/59 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Yes 2 X No Specify: 's Usual Occupation	Specify: White			
plete	15. Decedent's Education (Specify only highest grade completed in the complete	eted) (Give kind life. DO f	of work done during most of work NOT use retired)	king			
5	2	Dra	aftsman	Western Electric Co.	•		
Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 21220 USA							
	19a. Informant's Name/Relationship (Type. Print Lillian Slezak (Wife)			iral Route Number, City or Town, State, Zip Code) ore, Maryland 21220			
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	Date 20c. Location - City or Town, State 2008 Baltimore, Maryland	l				
	21. Signature of Funeral Services icensee) 22. Na Bru	ame and Address of Facility ZOZINSKI FUNETA	l Home P.A.			
	John W. Burkow	$\sqrt{R0}$ 140	7 Old Fastern Av	venue Essex, Maryland 2/22/			
	23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final	inat caused the death. Do not enter the on each line.	ne made of dying, such as cardiac	c or respiratory arrest, Approximate Interval Between nset and Death	n h		
	disease or condition resulting in death)	ue to (or as oconsequence of):	20013				
ner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying	us to (or as a consequence of):	Approximate Interval Between and Deconsequence of): Approximate Interval Between and Deconsequence of): Consequence of):				
=xamine	Cause (Disease or injury that initiated events c.	ue to (or as a consequence of):					
dicai	d						
Completed by Physician/Medical E	IF FEMALE: 23c. If ye 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ➡ 4 ☐ 9 ☐ Unknown 9 ☐ Unknown	23d. Date of delivery Month Day Year					
by PT	Part II. Other selficant conditions contributing	23e. Did tobacco use contribute to the cause of death 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unkn					
ered	Coronny h	24a. Was an autopsy findings avail prior to completion of cause	-				
d E o o	autopsy performed? death? 1 Yes 2 No 1 Yes 2						
D D	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	examiner?					
tion:	27. Manner of Death 28a.	Date of Injury 28b. Time of (Month, Day Year) Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how injury occurred	15		
Medical Certification: To	3 Suicide 6 Could not be 28e.	Place of injury - At home, farm, street, building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
dical C	(Check only 2 Medical Examiner: On			i, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)			
Me	29b. Signature and file of certifier 29c. License number 29d. Date signed (Month, Day, Year)						

15

State Registrar

DR. EDDIE NAKHUDA 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD.

32. Registrar's Signature

FEB 0 6 2008

TIMONIUM, MD 21093

Division of Vital Records,

Attending Physician: death. after death Diractor: A in by 0 within 24 hours a filled the

> State Registrar

Medical

4 Homicide

(Check only

29b. Signature and title of certifier

29a. Certifier

one)

Jude Wheres mo 32. Registrar's Signature 31. Date filed (Month, Day, Year)

FEB 06

7845

ess of person who completed cause of death (Item 23a) (Type, Print) Definoid

Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Ropod Glen Burnie, mil

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 2:09 A M Fe Jessie Mae Sherrod 3 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore Union Memprial Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ √ Director 78 218-28-3864 10-14-29 SC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r 28a-f show notified at N/A 1 Yes 2 No MD Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 835 Whitelock St 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. African Specify: 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than ' Self Elementary/Secondary (0-12) College (1-4or 5+) Hiarcare Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alton Smith Ella Mae Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Sherrod Perry/Daug 3028 Tiogo Pkwy, Balt., permit. Pages 1 and Department of Health Important: If item 27 any Injury or other to MD 21215 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Balt. County, MD King Mem Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hari P. Close F. 21. Signature of Funer Service License Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 2 weeks /Medical ralignant pleural effusion Examiner Sequentially list conditions r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed and bunial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buna Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2Д No Day Year 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ייה על Plospital or An. ייז על hours after death. "uneral Director: After h..."יין in by the funeral director." 1 X Inpatient 2 1 🗌 Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospius.
within 24 hours after
To the Funeral Dir 1 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD AT2438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) eppard laurice 201 WNIVERWITY PARKINAY BALTIMORE MD 21218 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2868 0 Registrar

DHMH 17 Rev 1/2001

08-00878 James Lamont Shorts

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 03216

nes Lamont 3	1	- For State Certific	cate of Death	Reg. No.			
Physicia		egistrar i. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Ye	3. Time of Death ar 1836 hrs		
ا Exami	ner	James Lamont Shorts		Month Day Ye January 31, 2008			
		a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Baltimore	4c. County	N/A		
		Harbor Hospital Center		8. Date of Birth(MM/DD/YYY			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b	irthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	7	Foreign Country)MD		
Director		220-64-4066 1XM 2 F 51	Yrs.	3/24/56	Country/		
	-	Usual Residence of Decedent			10d. Inside City Limits		
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und show	5	MD N/A Balt	imore	10g. Citizen of V	Vhat Country?		
f faryla	Director	10e. Street and Number	10f. Zip Code	USA			
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6 1721 an "r	let	Elementary/Secondary (0-12) College (1-4 or 5+)	Laborer	Const	ruction		
within iene.	Completed	17. Father's Name (First, Middle, Last)	18.Mother's Name	e (First, Middle, Maiden Surnar	ne)		
15-(filed Hyg doth t, the	ŭ	Edmond Graven	Carol S				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or	Rural Route Number, City or T	own, State, Zip Code)		
MD 21215-0036 42 should be filted within 72 hours after death with the Maryland full and Monid a Hygiene 12 hours after death with the Maryland n. 27 is marked other than "natural", or items 23a or 28a-f sho anmatic event, the Medical Examiner must be notified at once.	To	Caprice Diggs/niece	2446 Wilgrey Cour	t, Balt., MI	21230		
	D.L.I	20a. Method of Disposition 20b. Pla	ce of Disposition (Name of cemetery, matory or other place)		on - City or Town, State		
Ore ges 1 t of H : If i		1 X Burial 2 Cremation 3 Removal from State	. Zion Cem	8/08 Balt	., MD		
Baltimore, permit. Pages I at Department of Hee Important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Service Livensee	22. Name and Address of Facility Ha	ri P Close	F SVS PA		
Baltimore permit. Pages 1 Department of F Important: If i		21. Signature of Full State Control of the Control	5126 Belair Rd	. Balt MD	21206		
physician		23a. Part I. Ent., th. disease, or complications that caused the death. D	o not enter the mode of dying, such as cardiac	or respiratory arres, shock, or	heart Approximate Interval Between Onset and		
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uted Id ansit	Ĭ	d					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and a control of the Attention of t	Medical	XUNPENDED AMENDED 7.28a-f. DE	erME,g876, 1/14/08 TT				
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Box 687 e death certifice the attending p	Sic	1 Yes 2 No 9 Unknown g Unknown	5 Other (opecity)				
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Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:			telese	and due to the cause(s) and m	anner as stated.		
the III	Modical	29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check only one) 2 Medical Examiner for the basis of examination at and manner stated.	nd/or investigation, in my opinion, death occurr	ed at the time, date and place,			
5 ± 5		29b. Signature and title of certifier	29c. License number		e signed (Month, Day, Year)		
		/ / //	O.C.M.E.	Februa	ary 1, 2008		
Marocm	_	30. Name and address of person who completed cause of death (Item	1 23a)				
8 6 DOW	-	Mary G. Ripple MD. Deputy Chief Medical Exar	miner 111 Penn Street, Baltimore	, MD 21201			
	Stat	32 Pegistrar's Signatu	ure				
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State of Maryland / Department of Health and Mental Hygiene 2 0 0 0

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		•	State Registrar			Cei	rtificate of	Death		Reg. No.	2008	03211
	N/A		1. Decedent's Name (First, Middle	e, Last)					2. Date o Month	f Death Day	Year	3. Time of Death
	Physici: /Medic		Raymond W	. Schmidt					Febr	uary 5	, 2008	9:07 A M
	Examin		4a. Facility Name (If not institution	-			4b. City, Town,	or Location of Dea	ath		County of Death	
		d.	Gilchrist				_	WSON Ir If Under 24 Hr	n 10 D-1-		Baltimo	
	Funeral		5. Social Security Number	6. Sex 7. A		ast birthday) Yrs.	Months Days		(Month	Birth , Day, Year)	Coui	place (State or Foreign atry)
	Director		174-24-4375 Usual Residence of Decedent		78	_			Jan.	1, 19	JUFEIII	isyivania
	yland Iow at		10a. State 10b. County		10c. City	, Town or Lo	ecation				1	0d. Inside City Limits
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	th the or 28 e not	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Coul	ntry?
	ath wi		302 Cantat		31			1136			U.S.A	
	er de c	Funeral	11. Marital Status	12. Was Decedent	?	S. 13.	Was Decedent of If Yes, specify Cu	f Hispanic Origin? aban, Mexican, Pue	(Specify Yes o erto Rican, etc	r No- 1	 Race - Americ Black, White, 	
36	rs afte	by F	1 □ Never Married 2 □ Mar X Widowed 4 □ Divorced	The Car Carvo	[№] 194		1 □ Yes X2XI N	o Specify:			Specify: Wh	nite
Ş	thou atura	pa	15. Deceder	nt's Education	195	16a. Dece	dent's Usual Occ	upation		16b. Kir	nd of Business/In	dustry
215	hin 7% e. an "na Media	Completed	(Specify only higher Elementary/Secondary (0-12)	cst grade completed) College (1-4or	5+)	life.	kind of work don DO NOT use retii	ne during most of w red)	orking			
21,	gd with	5	12			Dis	trict	Manager			Retai1	
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<u>v</u> la	ould Men larke	2	Otto S			T 404 14 77		et and Number or		(Unkno		- Codo)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at once.		19a. Informant's Name/Relation Jeffrey Schm			1		Ct. Rei				
9	1 and Healt em 2		20a. Method of Disposition	idt / Son	20b. F	Place of Dieno	neition (Name of		Date		cation - City or T	
<u>lo</u>	ages ant of t: If it		XX Burial 2 □ Cremation 4 □ Donation 5 ☑ Other (La	emetery, cre	matory or other p	ace)	/8/08	Sv	kesvi1	le. MD
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	'Y		30. Name and address of person Danieut Debi 31. Date filed (Month, Day, Year FEB 0 6	n who completed cause of	death (Iter	n 23a) (Type	ither is	ST. S1119	2 200	RAI	TIMARE.	40 21204
	St	ate	31. Date filed (Month, Day, Yea	r) 32. Regis	strar's Sign	ature	acks	- Couli	2 ~~~	210	WI WILL	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Year Physician 05:33 PM Sanders Jr. 03 2008 Feb Aaron /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital SouinT Agnes Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, O4 22 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign ^{Year)} 36 Months 1 € M 2 □ F NC 71 215-30-7319 Usual Residence of Decedent 10c. City, Town or Location 10a State 10d. Inside City Limits 10b. County 1 XYes 2 No Director NA Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 U.S.A. 3320 Brighton Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Soul Sorce 12th grade Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rosa McCullers Aaron Sanders Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3320 Brighton Street, Baltimore, Md 21216 Dolores Sanders-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State

Physician /Medical Examiner

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

within 72 hours after death with

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than '

permit. Pages 1 Department of H Important: If ite any Injury or ot

Baltimore, Maryland 21215-0036

P.O. Box 68760

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Division or Vital

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or Attending Physician:

To the Hospital

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Examiner use as the burial-trans the attending physician ō detached been signed by should be detac After this certificate has page 2 funeral director, within 24 hours after death To the Funeral Director: filled in by the

4 ☐ Ponation 5 ☐ Other (Spec	ify)	Arbutus	s Memorial	2/9/08	Arbutus,	Ma
21. Signalure of Funeral Service Lice	ensee		22. Name and Address of F March F/H W 4300 Wabash	est _	imore, Md	21215
23a. Part . Enter the disease, or cor shock, or heart failure. List only	nplications that caused y one cause on each line	the death. Do not	enter the mode of dying, suc	h as cardiac or respiratory a	arrest,	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsi		-difficile			Day S
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):						
•	d					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome p 1 ☐ Live birth : 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of de Month	elivery Day Year

Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 XYes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ⋈ No 1☐ Yes 2☑No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 X Inpatient 2 ER/Outpatient 3□ DOA 2 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 28e. Place of injury At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗡 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

AVE

P120655

29d. Date signed (Month, Day, Year)

21229

Feb

MD

Registrar

31. Date filed (Month, Day, Year)

Saint Agnes

29b. Signature and title of certifier

FEB 0 6 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital



900

MD

caton

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Suber Marie 6:25a.M 02 03 2008 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Randallstown Future Care Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex Birthplace (State or Foreign Country) 1 □ M 2 F 92 15 220-24-1898 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Baltimore Randallstown 1 ☐ Yes 2X No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21133 5412 Old Court Road Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Yes No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Black þ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Homes Private Care Giver 9th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alice Salters Willie Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7 Camano Ct., Randallstown, Md 21133 19a. Informant's Name/Relationship (Type, Print) 7 Camano Ct., Randallstown, Md Patricia Evans-Niece 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mayfield Chapel

Bayfield Church 20a. Method of Disposition Date 20c. Location - City or Town, State X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 A Donation 5 ☐ Other (Specify) 2/9/2008 Duncan, SC 21. Si mature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerot Colonan Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FFMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pertenen lementer 1 Yes 2 No 3 Probably 4 Unknown direale 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Chronic OBhitive perforn

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

'natural", or Items 23a or 28a-f show dical Examiner must be notified at

Department of Health and Mental Hygiene, important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once.

Pages 1 and 2 should be nent of Health and Mental

death

filed within 72 hours after

Maryland 21215-0036

Baltimore,

Examiner as the burial-transit and physician Physician/Medical attending p signed by the a Completed by ate has page 2 s certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. Be Certification: To

law requires that the death certificate be execut

P.O. Box 68760,

Division or Vital Records,

25. Was case referred to medical examiner? Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 1 ☐ Yes 2 No 28b. Time of

26. Place of Death (Check only one) Other:

 $f \zeta$ Nursing Home 5 \Box Residence 6 \Box Other (Specify)

28d. Describe how injury occurred

531 old court road, MD-21133

1 ☐ Yes 2 ☐ No

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 4 Homicide

28a. Date of Injury (Month, Day Year)

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

29a, Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

3 AMBALAVANAN

State Registrar

Medical

31. Date filed (Month, Day, Year)

32. Registrar's Signature

BACASUBRAMANIAN,

FEB 0 6 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 03220 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY Day 4 **Physician** SARRA SOMIN 2008 10:38A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death **Examiner** 3615 FORDS LANE, #308 BALTIMORE N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 05/23/1918 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 N F Months Days Hours Min. ŰKRAI NE 092-60-2704 89 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show ral", or items 23a or 28a-f shore Examiner must be notified at MD N/A BALTIMORE 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with the Hygiene. Hygiene. Other than "natural", or Items 23a or 2 3615 FORDS LANE, #308 21215 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No if Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE Specify: 3 XWidowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w. Department of Health and Mental Hyglen Important: If item 27 is marked other the any injury or other traumatic event, the once. 10 ASSISTANT PHARMACIST PHARMACY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be YEFIM KOGAN UNOBTAINABLE ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ZOYA PESKIN / DAUGHTER-IN-LAW 22 WINDWHISPER LANE, ANNAPOLIS, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State HAR SÍNAI CONG. 02/05/2008 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. Mit Le 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) CARSIO DU MONAM Due to (or as a consequence of): **Physician** Immpdite /Medical **Examiner** COLONAN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) been signed by the should be detached 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? 1□ Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mo P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28d. Describe how injury occurred Certification: Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral L 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number berson who completed cause of death (Item 23a) (Type, Print) 30. Name and address JAKO3017 JULIAN 32. Fegistrar's Signature 2835 BALTMORE MD State 2008 BON Registrar

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 6:10 Dorothy Templon 2008 Αм February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Riverview Care Center Baltimore Essex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 23, 1913 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 X F 218 16 4895 Pennsylvania Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show r 28a-f show notified at 1 ☐ Yes 2X No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? ral", or items 23a or Examiner must be 2106 Middleborough Rd. 21221 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give filed within 72 hours after 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. er than "natural", o , the Medical Exan ģ Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Clerk Pharmacy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Emil Olson Margaret Ellen McCartney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis L. Templon (Son) 2106 Middleborough Rd. Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gardens 2/7/2008 Bel Air , Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Bervice Licensee ^{22, Name and Address of Facility} Bruzdziński Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Immediate Cause (Final anca emer 2-14mar **Physician** disea or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending for use as as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has birector, page 2 s autopsy death? 1 ☐ Yes 212 No 1 Yes 2 No or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) Injury 1 X Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No after death.

I Director: A din by the fu 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral D

completely filled in To the Hospital i 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D-38754 02-05-2008 M-D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 709 BASTERN BWD. MD-21221

Registrar DHMH 17 Rev 1/2001

State

WASBEM

6

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Donald W. Taylor 2008 FEBRUAR) 04 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HEALTHCARE AGNES TIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | MAR 25, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 **∑**M 2 ☐ F 163-22-5306 80 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 XNo Director Baltimore Catonsville Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene. Important: If then 27 is marked other than "nature" any injury or other traumatin mental police. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 USA 3 Summit Hill Court #A4 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No WWII If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 Married 1 □ Yes 2 👿 No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Security Systems Analyst 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Austin D. Taylor Edna Stough ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Summit Hill Ct. #A4 Catonsville, MD 21228 Betty R. Taylor - wife 20b. Place of Disposition (Name of cemetery, crematory or other place)

Lake View Memorial Park 2/8/2008 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Eldersburg, MD Haight Funeral Home & Chapel, P.A. P.O. Box 195 Sykesville, MD 21784 21. Signature of Funeral Service Licens (410-795-1400)23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myocardial 6 hours Physician Aute Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uniknown Renal 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performe Bladder Cancer 2.☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ٩ 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

TAYOR, DONAL

The law requires that the death certificate be executed attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760, signed by the a Id be detached for certificate has birector, page 2 s or Attending Physician:

/Medical

Examiner

Medical Certification:

Director

r 28a-f show notified at

within 24 hours after death

To the Funeral Director:
completely filled in by the

State Registrar

6 ☐ Could not be determined

and manner stated.

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number B19914795

Bulkinger.

29d. Date signed (Month, Day, Year) comary 5, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 south cation Avenue

MD

2008

Meghan Checkley 31. Date filed (Month, Day, Year)

FEB 06

29b. Signature and title of certifier

4 Homicide

29a. Certifier (Check only one)

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygieneo Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death EBRUARY Pay Physician 2008 11:16AM Charles Robert Thompson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death Examiner Center Baltimore Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 950 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1**√** M 2□ F Maryland 57 Director 214-56-9970 Usual Residence of Decedent 10d. Inside City Limits r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes & ☐No Director Penn. York Hanover 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be 873 Mcallister 17331 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 12. 2 □ No 1970-If Yes, Give Year or Dates: 1972 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or itel 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 💢 🐧 o Specify Specify: ģ 3 Widowed 4 Divorced White Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Truck D<u>river</u> Trucking Co traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Thompson Lillian World ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any Injury or other traun once. Joyce Thompson - wife St. 873 Mcallister Hanover, PA. Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Garrison Forest 1X Burial 2 □ Cremation 3 □ Removal from State Feb. 4 □ Donation 5 □ Other (Specify) Owings Mills, Maryland Veterans Cemetery 2008 21. Signature of Fundal Price 22. Name and Address of Facility Eckhardt Funeral Chapel P.A 21102 3296 Charmil Dr. Manchester, Approximate Interval Between Onset and Death Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. sho Immed te Cause (Final disease or condition resulting in death) GASTROINTESTINAL BLEEDING **Physician** /Medical Due to (or as a consequence of): Examiner MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, physician a the burial Physician/Medical attending for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown SEPSIS SYNDROME Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1☐ Yes 2♠ No 2□ No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident ours after death.
neral Director: / 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 24 hours a Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical To the Fund completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D 46356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND 21204 OSLER DRIVE. TOWSON. KHOSROW TABASSI, M. D. . 7601 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 6 2008

Registrar

		State of Maryland / I	Department Certificate	of He	ealth and M		iene2	008	03224
AL		Registrar 1. Decedent's Name (First, Middle, Last)				2. Date of Dea			3. Time of Death
Physic		Thomas	Tisda.	le	Sr.	Month O.J.	29	Year 2008	9:35a.M
/Med Exam		4a. Facility Name (If not institution, give street and number)			Location of Death	01		inty of Death	J.55a.
Exam	ner				imore			,	
Funera		Sinai Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last bi	rthday) if Under 1	Year	if Under 24 Hrs.	8. Date of Birth		9. Birthr	place (State or Foreign
Director		250-38-4872 ^{1™ 2□F} 80	Yrs. Months I	Days	Hours Min.	(Month, Day 12 20	27	Coui	SC SC
da -	4	Usual Residence of Decedent				12 20			
/lanc ow		10a. State 10b. County 10c. City, Tow	n or Location					1	10d. Inside City Limits
ING ZIZIS-UUSD be filed within 72 hours after death with the Marylan ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ţ	MD NA Ba	ltimore						¹XYes 2□No
the 28a	Director	10e. Street and Number	10f. Zip C	Code		1	0g. Citizen	of What Cour	ntry?
with with the		1507 Winners Dood		27	218		TT	.S.A.	
eath	Funeral	15.27 Kingsway Road 11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decede			ecify Yes or No-		Race - Americ	can Indian,
iter d	Ë	1 Never Married 2 Married 1 Yes 2 No	If Yes, specif	y Cubar	spanic Origin? (Spe n, Mexican, Puerto	Rican, etc.)	1	Black, White,	etc.
rs af	þ	3 Widowed 4 Divorced Year or Dates:	1□Yes 🛣	□No	Specify:		Spe	ecify: B.	lack
hou hou sale			. Decedent's Usual	Occupa	tion	1	16b. Kind o	of Business/In	dustry
n 72 n 72 n "na ledic	Completed	(Specify only highest grade completed)	(Give kind of work life. DO NOT use	done di retired)	uring most of worki	ng			•
with energy than	Ę	Elementary/Secondary (0-12) College (1-4or 5+) 10th grade na	Labore	r		tw	hitt	ina &	Turner C
filled Hygi		17. Father's Name (First, Middle, Last)	Labore		18. Mother's Name				
yially AILIPOUSO ould be filed within 72 hours after death with the Manyland Mental Hygiene. Arked other than "natural", or items 23a or 28a-f show atic event, the Medical Examiner must be notified at	Be	Edward Tisdale			Sealy T	hompso	n		
ages 1 and 2 should be filed within 72 hours af nt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or other traumatic event, the Medical Exami	2		b. Mailing Address (S					wn. State. Ziu	O Code) 21215
d2s d2s thar thar 7 is		, , , ,	29 West				. ,		, CTTT
						Date		on - City or To	
Pages nent of int: If it		1 LXBuriai 2 Li Cremation 3 Li Removal from State	of Disposition (Name ery, crematory or oth			00		ew, S	
ther ther tant		4 Donation 5 □ Other (Specify) Ebenz				00	Andr	ew, b	<u> </u>
permit. Pages 1 au Department of Hea Important: If Item any injury or othe once.		21. Signature of Funeral Service Licensee	22. Name and March						
		Hume of shompeur	4300 W	aba	sh Ave.	Balti	more	, Md	21215
		23a. Part 1 Enter the disease, or complications that caused the death. Do shock or heart failure. List only one cause on each line.	not enter the mode	of dying	g, such as cardiac o	or respiratory arr	est,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	10 CA	Re	NONL	A			Onset and Death
/Medical		resulting in death) a. Due to (or as a consequence	+	_		. 1			/ 1
Examiner									6 month
	je 📕	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):						
cuted d ansir	Examiner	Cause (Disease or injury that initiated events							
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icate be executed physician and sthe burial-transit	dical	d							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edi							1	-
r.C. box of the death certification of by the attending petached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy					23d.	Date of deliv	ery
death death death death	icia	in the past 12 months? 1 Ves 2 No 4 Pregnant at time of death	h 3 □Ectopic preg 5 □ Other (spec					Month	Day Year
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res that the de signed by the a		Part II. Other significant conditions contributing to death but not resulting	in the underlying cau	use give	n in Part I.	23e. Did to	bacco use	contribute to t	the cause of death?
uires sign	Completed by	HYPERTENSION				1 □ Y	es 2 N	lo 3□Pro	bably 4 Unknown
w require been signature should b	ete					24a. Was a	an 2	4h Were auto	opsy findings available
has has	E					autop	sy	prior to co death?	impletion of cause of
vical necology, sician: The law requires the certificate has been signed rector, page 2 should be defined.						1□ Yes	2 No	1 □ Yes	2 □ No
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Ing F	l ii	1 Natural 5 □ Pending (Month, Day Year)		c. Injury Work		28d. Describe h	ow injury of	ccurrea	
tend eath tor: /	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place of injury 4t home for	M		′es 2□No				
i or Attending Physical Colored after death. Director: After this in by the funeral di	Certification:	4 Homicide determined 28e. Place of injury - At home, for building, etc. (Specify)	arm, street, factory,	office		28f. Location (S City or Tow	treet and N n, State)	umber or Rur	al Route Number,
To the Hospital or Attending Phyminin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Se								
Hosp 4 hou Fune ely fil	cal	29a, Certifier (Check only (Ch							
the hin 24 the f	Medical	one) and manner stated.	1 00						5 14 1
With Con	2	29b. Signature and title of certifier	29c.	License	number			igned (Month,	
	/	Kaje, M-D	1	14	5244		011	31/0	3
h		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)			1 1 2		,	
9		10 N. Greene Street.	(Type, Print) BALTI	MD	RE, 1	VID -	212	01.	
S	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	4						
Regis	trar	FFR 0 6 2008	Acast	,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Ma	iryianu /		tificate of D			eg. No.		03	225
	sicia		1. Decedent's Name (First, Middle, Lateral Charles	w. Vest	al	Jr.			2. Date of Deat Month Februar		2008	3. Time of 5:25	Death P M
	edica mine		4a. Facility Name (If not institution, give				4b. City, Town, or I	Location of Death		_	County of Death		
		*	304 Liberty Road 5. Social Security Number 6. S	7 Age	(In yrs. last I	hirthday	Essex If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	<u></u>	Baltin		or Comies
Fune Direc			214 50 5100 Usual Residence of Decedent	X 2 F	60	Yrs.	Months Days	Hours Min.	(Month, Day, Feb. 02	Year) ,194	18 Mary	place (State ontry) Iland	or Foreign
/land ow	a l	}	10a. State 10b. County		10c. City, To	wn or Loc	ation					10d. Inside C	ity Limits
Mar a-f sh		ctor	Maryland Baltimor	e		E	ssex					1 ☐ Yes	² ∏No
or 28		Oire	10e. Street and Number				10f. Zip Code		11	0g. Citize	en of What Cou	ntry?	
ath w	1	Funeral Director	304 Liberty Road	T-12-11-1		10.10	1	221			USZ		
ter de	5	nue	11. Marital Status 1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 XYes 2 N If Yes, Give		13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	Rican, etc.)	1	4. Race - Ameri Black, White		
JUSO lours af ural"; or		کر ا	3 ☐ Widowed 4 ☐ Divorced	rear or Dates.	13/1		••	Specify:				hite	
hin 72 h		Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5-		a. Deced (Give I life. D	ent's Usual Occupa kind of work done du OO NOT use retired)	tion uring most of worki	ing	16b. Kin	d of Business/Ir	ndustry	
with year that		E 0		2	"	(Owner/Ope				otograp	ohy	
be file doth		Be	17. Father's Name (First, Middle, Last,					18. Mother's Name					
y id nould if Men narke		၉	Charles W. Ve		1 4	Ob Mailin	g Address (Street a		ta M. Po			- Codo)	
iges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 2715 marked other than "natural", or items 23a or 28a-f show when trainmain examt the Market Examiner must be notified at			Catherine V. Fore		er)	16 H	orney Cou	rt Esse	ex Maryl			p Code)	
Des to Territor He item			20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐	Removal from State	1		sition (Name of natory or other place				ation - City or T		
Deficiency Pages Department of mportant: If it			4 Donation 5 ☐ Other (Specif	54	Bayvi		rematory				imore,		
partition of Health a Department of Health a Important: If item 27 is any follow or other tasks	ouce.		21. Signature of Funeral Service Lice	see			Name and Address						
A WAY			23. Part1. Enter the disease, or conshock, or heart failure. List only	n ication. If at caused ne conse on each lin	the death. De	o not ente	er the mode of dying	, such as cardiac	or respiratory arre	est,		Approxima Interval Be	te tween
Physici	an		Immediate Cause (Final disease or condition	Transfer	rmed	B	- cell 1	4 m f han	a			Onset and	
/Medio	-		resulting in death)	Due to (or as a	a consequenc	e of):	D OFFICE					2 1/	16-80
xaiiii	440	<u>.</u>	Sequentially list conditions,	b. Indolen Due to (or as a	T B	- се se of):	ll win	homa				3/2 4	eau 5
uted		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Trans for Due to (or as a b. Indolen Due to (or as a c. Chrane	Lyn	pho	cytic	Leuker	nia		Į.	3/2 4	ears
tificate be executed g physician and		EX	resulting in death) Lest	Due to (or as a	a consequenc	e of):	-						
ficate be ex		edical	•	d									
certific certific ding	3		IF FEMALE:	23c. If yes, outcome p	pf pregnancy					2:	3d. Date of deliv	/erv	
death ce		Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal dea		Ectopic pregnancy Other (specify)			-	Month		Year
by the		hys	9 Unknown	9□Unknown					- 1	\perp			
es tha gned	8	by P	Part II. Other significant conditions	contributing to death bu	ut not resulting	g in the un	derlying cause give	n in Part I.			e contribute to		/
w requires been signed		ted							1 ∐ Y€	es 2]No 3□Pro		Unknown
e law))	Completed							24a. Was a autops perform	y]	24b. Were aut prior to co death?	opsy findings ompletion of o	available cause of
n: The ficate	2		05 W						1□ Yes	2 19 No	1 ☐ Yes	2 □ No	
sicial s certi		Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	nt 2□FR//	Outpatient	t 3 DOA Other	26. Place of Deatl	me 5 Reside		Other (Spec	i6/)	
g Phy ger this		ا ا	27. Manner of Death	28a. Date of Injur (Month, Day	ry 28t	o. Time of	28c. Injury Work		28d. Describe ho			шуу	
ath, or: Aft		atio	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	n	rear)	Injury		es 2 □ No					
i or Atte		Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of inju building, etc	iry - At home, c. (Specify)	farm, stre	eet, factory, office		28f. Location (St City or Town	reet and n, State)	Number or Ru	ral Route Nur	nber,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and commissive filled in by the funeral director, send 2 should be described for use as the burial land in the filled in the first send of the last send of the las		Medical C		hysician: To the best of miner: On the basis of and manner sta	examination								(s)
To the Within To the	100	Me	29b. Signature and title of certifier				29c. License	number	2	9d. Date	signed (Month	, Day, Year)	
3/			No			WD	Do	05889			ary a	t 200	8
107	,		30. Name end address of person who lieuc Browner	, MD 4	940	Eas-	tem Ava	inue All	11 Ba	elti	more, M	10 21	224
	Stat		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	2 4	6 11 -						
Rec	y 1/20		FEB 0 6	2008	ar's Signature	1	43492)						

DHMH 17 Rev 1/2001

Please Tr	une or Print in Bloo	k Indolihla Ink - Engura Al	II Copies Ar	o Logiblo	
1_ For	State of Maryland / D	k Indelible Ink. Ensure Al Department of Health and M Certificate of Death	lental Hygier	ne2008	03226
Registrar 1. Decedent's Name (First, Middle, Last)		- Death	Reg. 2. Date of Death	No.	3. Time of Death
WALTER FRANKLIN	WIGLEY JR		Janüary 3	Pay 2008ar	11:00А м
4a. Facility Name (If not institution, give st 407 Aigburth Road	reet and number)	4b. City, Town, or Location of Death TOWSON		4c. County of Deeth Baltimore	è
5. Social Security Number 6. Sex 219–22–6934	7. Age (In yrs. last birt	thday) If Under 1 Year If Under 24 Hrs. Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye November 21	er) 9. Birthp	lece (State or Foreign http: / I and
Usual Residence of Decedent	. 02		TRACTIBET 21	,1525 1101)	rund
10a. State 10b. County	10c. City, Town	or Location		1	0d. Inside City Limits
Maryland Baltimore	e Tov	wson			1 Yes 2 No
10e. Street and Number		10f. Zip Code		Citizen of What Cour	itry?
407 Aigburth Road		21286		USA	
11. Marital Status	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2.	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	etc.
3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 💥 No Specify:		Specify: W	nite
15. Decedent's Educi (Specify only highest grade	completed)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 16b	. Kind of Business/Ind	dustry
Elementary/Secondary (0-12)	College (1-4or 5+) 4 Pt	urchasing Manager		Brewery	
17. Father's Name (First, Middle, Last) Walter Franklin Wig	ılev Sr		e (First, Middle, Maid .ourimore	den Sumame)	
19a. Informant's Name/Relationship (Typ	e, Print) 19b.	. Mailing Address (Street and Number or Run		ty or Town, State, Zip	Code)
Joanna G Wigley		07 Aigburth Road Tows			
20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Re	emoval from State cemeter	y, crematory or other place)		Location - City or To	
'4 Donation 5 Other (Specify)	A			ltimore, N	
21. A nature of Fun at Symp Licensee	MPMAL BIS	22. Name and Address of Facility Mita			
23a. Part1. Enter the disease or complic shock, or heart failure. List only one	ations that caused the death. Do recause on each line.	not enter the mode of dying, such as cardiac		c, narjia	Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death)	Dilated Cardio	omyopathy			Onset and Death Years
resulting in death)	Due to (or as a consequence of	of):			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	of):			
that initiated events c. resulting in death) Last	Due to (or as a consequence of	of):			
d.					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregnancy 1 Live birth 2 Petal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ery Day Year
Part II. Other significant conditions cont	ributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobaco	co use contribute to the	ne cause of death?
Chronic Osteomyeli			1 🗆 Yes	2 □ No 3 Prob	ably 4 Unknown
			24a. Was an	24b. Were auto	psy findings available

Physician /Medical Examiner

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be natified at once.

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

Be Completed by Physician/Medical Examiner within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Medical Certification; To

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760,

26. Place of Death (Check only one)

prior to completion of cause of death?

1 Yes 2 No autopsy performed?

1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural
2 Accident

5 Pending investigation 6 Could not be determined

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

3 Suicide

4 Homicide

to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D48261

29d. Date signed (Month, Day, Year)

フハロ

28a. Date of Injury (Month, Day Year)

February 2, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10753 Falls Road Lutherville, Maryland 21093 Howard Levy M.D.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

31. Date filed (Month, Day, Year) FEB 0 6 2008

			For State of Maryl		partment of H <i>ertificate of L</i>		Mental Hyo	giene	0000	00007
			Registrar 1. Decedent's Name (First, Middle, Last)		erinicate of L	Jeatn	2. Date of Dea	Reg. No.	<u> 2008</u>	3. Time of Death
	Physicia		June Watsor	2			Month	Day	2008	1210 - 2
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c.	County of Death	
	(4) (4)		University of Marylan	d Medica		altimor	e CITY	'		
ľ	Funeral		35-37-	yrs. last birthda 2 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	r, Year)	Cor	nplace (State or Foreign untry)
	Director	0	Usual Residence of Decedent	2			Feb. 25	, 19	35 Mary	Tane
	rylanc how			City, Town or	Location					10d. Inside City Limits
	e Ma Ba-f s	Director		andywi	ne					1 Yes 2 No
	with th	Dire	10e. Street and Number		10f. Zip Code			-	zen of What Co	untry?
	eath '	Funeral	14701 Gibbons Church Rd.	n U.S. 1	20613 3. Was Decedent of Hi	snanic Origin? (Si	necify Yes or No-	U.S.	A . 14. Race - Amer	ican Indian,
0	riter d riten	Fun	Armed Forces?		3. Was Decedent of Hi		o Rican, etc.)		Black, White	, etc.
2-0036	be filed within 72 hours after death with the Maryland rital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 / ☐ (No	Specify:			Specify: B1a	ack
7	"natu	letec	15. Decedent's Education (Specify only highest grade completed)	16a. Dec	cedent's Usual Occupa ive kind of work done o e. DO NOT use retired,	ation during most of wor	king	16b. Kir	nd of Business/I	ndustry
7.	withir iene. than the Me	duc	Elementary/Secondary (0-12) College (1-4or 5+)		ellant Bas			Nava	al Ordin	nance
ğ	filed with Hygiene other than	Be C	17. Father's Name (First, Middle, Last)				ne (First, Middle,			14.1.00
Maryland	should be fand Mental Is marked of sumatic ever	To B	Sylvester Barnes			Mazie Sm	ith			
<u>a</u>	2 sho and f is ma is ma		19a. Informant's Name/Relationship (Type. Print)		ailing Address (Street a					'
	es 1 and 2 should t of Health and Ment fitem 27 is marked ir other traumatic e		Hugh Watson Sr. (Husband) 20a. Method of Disposition 20		1 Gibbons		d. Brand			
בסר	Pages nent of H int: If ite		I M Dullal 2 Cremation 3 Removal nom State		sposition (Name of rematory or other place	1			cation - City or	
Baltimore,	permit. Page: Department o Important: If i any Injury or once.		4 ☐ Donation 5 ☐ Other (Specify) Ma 21. Signature of Funeral Sendee Ligenese	iryiand	Veteran's 22. Name and Addres		-2008		Ltenham,	
ñ	Imp Dep		1 1/01/ d 1// h 1.	100963					•	n, MD 20735
١	7		23a. Part1. English the classe, or complications that caused the dishock, princart failure. List only one cause on each line.	eath. Do not e	enter the mode of dying	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician				cytic le					Onset and Death
pts.	/Medical Examiner		resulting in death) Due to (or as a con	sequence of):	J.					
	40	er	Sequentially list conditions, if any, leading to immediate Due to (or as a con	sequence of):				-		
	ansit Add	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
Ď,	an an	Exa	resulting in death) Last Due to (or as a con	sequence of):						
04/8	ificate be executed Thysician and Is the burial-transit	dical	d							
0	ding page as	/Mec	IF FEMALE: 23c. If yes, outcome pf pre	ananov						
X O D	death certific s attending p d for use as	cian	in the past 12 months?	etal death	3 □Ectopic pregnancy 5 □ Other (specify)			2	3d. Date of deli Month	very Day Year
j.	0 0 0	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown							
λ, J	requires that the een signed by the rould be detache	by P	Part II. Other significant conditions contributing to death but not	resulting in the	e underlying cause give	en in Part I.	23e. Did to	bacco u	se contribute to	the cause of death?
g	equire sen sig ould b						1 🗆 Y	'es 2[□No 3□Pro	obably 4 Onknown
Hecord	The law rate has be page 2 sh	Completed					24a. Was autop	SV	prior to c	topsy findings available completion of cause of
<u> </u>	sician: The lav certificate has rector, page 2						1□ Yes	med? 2 X No	death? 1 ☐ Yes	2□No
VII	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inputient	2 □ EP/Outpat	ient 3 DOA Othe	or.	th (Check only o			w.
0	ding Phys	\vdash	27. Manner of Death 28a. Date of Injury	28b. Time	e of 28c. Injury		ome 5 Resid			ory)
101	ath. or: Aft	atio	1 Natural 5 □ Pending (Month, Day Yea 2 □ Accident investigation	r) Injur		Yes 2 □ No				
UIVISION	or Atter ter de iirecte n by ti	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - A building, etc. (Sp	it home, farm, ecify)	street, factory, office		28f. Location (S City or Tow	treet and n, State,	d Number or Ru)	ral Route Number,
ב	pital o		29a. Certifier 1 ★ Certifying Physician: To the best of my	knowledge de	eath occurred at the time	o date and place	and due to the	201100(0)	and manner as	etated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.	nination and/or	r investigation, in my or	pinion, death occu	urred at the time,	date and	place, and due	to the cause(s)
	To th Within To th comp	Me	29b. Signature and title of certifier		29c. License			29d. Date	e signed (Month	n, Day, Year)
			Defra Koldwill M	10	/>	432		Fe	62,20	08 Ne, HD 2170
	3		30. Name and address of person who completed cause of death (pe, Print)	0 1-		/ -	2011	1/2 OID=
A	Sta	te	Dama Koldobski y 31. Date filed (Month, Day, Year) 33. Registral's Si	ignature	5 22	J. 61	une s	TF	scitme	arc, My 2/20
3.	Registr		31. Date filed (Month, Day, Year) FEB 0 6 2008	K L	ack 1					
			The state of the s	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 8 perfit g882,08728/08dhb Certificate of Death Red. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 02. 02 2008 WILLIAMS **Physician** TUANITA /Medical acility Name (If not institution give street and number) 4b. City, Town, or Location of Death Examiner Nousing Home ummit 5. Social Security Number last birthday) **Funeral** 072-20-0930 1 ☐ M 2 💢 F Months 0571771923 Director filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County a or 28a-f show t be notified at 1 Yes 2 □ No HMore Director 10e. Street and Number 10g. Citizen of What Country? USA "natural", or Items 23a Funeral 14. Race - American Indian, . Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Important: If item 27 is marked other than any injury or other traumatic event accept. College (1-4or 5+) je Keeping Supervisor Baltimore Father's Name (First, Middle, La Be eanora lorris lar ves Informant's Name/Relationship liece 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐Removal from State 4 Donatie 5 Total (Specify) Services 21. Signature of Juneral ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the Immediate Cause (Final **Physician** Dery disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of Injury) that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and certificate be exect Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 N 1 | Inpatient 2 | ER/Outpatient 3 | DOA မှ After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) and title of confier 29b. Signate MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TURAKUIA 1009 31. Date filed (Month, Day, Year) 32 egistrar's Signatur State Registrar FEB 06 2008

		_ FOI	eartment of Health and Mental Hygiene ertificate of Death Reg. No. 2008 03229
Physici		Decedent's Name (First, Middle, Last) Yovani P Alvarado	2. Date of Death Month Day Year 1847 M
/Medi Examir		4a. Facility Name (If not institution, give street and number)	January 14, 2008 1547 114b. City, Town, or Location of Death Silver Spring Montgomery
Funeral		Holy Cross Hospital 5. Social Security Number 6. Sex 1□ M 2X F 49 Yrs.	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Md. Montgomery 10c. Silver 10e. Street and Number 2202 Greenery Lane #202 11. Marital Status 12 Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No It Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4th College (1-4or 5+) Add 17. Father's Name (First, Middle, Last) Ramon Otilio Alvarado	ocation 10d. Inside City Limits
re, Mal		Jorge Alvarado (Brother) 22	O2 Greenery Lane #202 Silver Spring, Md. 20906
Baltimore, cermit. Pages 1 ar Department of Hea Important: If Item; any injury or other		4 □ Donation 5 □ Other (Specify)	Partory Cromatory 01-17-2008 Beltsville, Md. 22. Name and Address of Facility W. H. Bacon Funeral Home, Inc.
Dep		Wanesa C. Dacen CC 26/1	3447 14th Street, N.W. Washington, DC 20010
B/60, ate be executed American and physician and the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not each shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cardio-puthonary Due to (or as a consequence of): Brain Anoxia Due to (or as a consequence of): Hypoxic Encepha C. Wegener's Granu d.	Arrest Interval Between Onset and Death lopathy
the death certification by the attending priched for use as	Physician/Med		□Ectopic pregnancy 23d. Date of delivery Month Day Year
Cords, P.O. w requires that the deben signed by the should be detached	5	Part II. Other significant conditions contributing to death but not resulting in the Renal Failure	underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒Unknown
The lay ate has page 2	Completed		24a. Was an autopsy findings available prior to completion of cause of death? 1□ Yes 2√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√
VISION OF Attending Phy Pr death. ector: After this by the funeral d	Certification: To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ⋈ No 27. Manner of Death 1 ⋈ Natural 5 □ Pending investigation 3 □ Suicide 4 □ Homicide 28a. Date of Injury (Month, Day Year) (Month, Day Year) 28b. Time (Month, Day Year) 28b. Place of injury - At home, farm, building, etc. (Specify)	of 28c. Injury at Work? 28d. Describe how injury occurred M 1 □ Yes 2 □ No
To the Hospital or within 24 hours afte To the Funeral Dis completely filled in	Medical Cer		ath occurred at the time, date and place, and due to the cause(s) and manner as stated. investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier Rahmaniun	29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 3 January 15, 2008
R(5)		30. Name and address of person who completed cause of death (Item 23a) (Typ Majid Rahmanian, M.D. 1500 Fo	e, Print) rest Glen Rd. Silver Spring, Md. 20910
Sta Regist		31. Date filed (Month, Day Year) JAN 2 2 2008 32. Registrar's Signiture	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:30 PM 1/15/2008 Jesse Huntley Ayer, Jr. /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Laurel Regional Hospital Laurel Birthplace (State or Foreign Country) If Under 1 Year | Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Hours Min 1 1 M 2 □ F 62 10/11/1945 Cheverly, MD 214-48-6593 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10c City Town or Location 10d. Inside City Limits 10a. State 10b. County ms 23a or 28a-f show must be notified at 1X Yes 2 No Prince George's Director MD College Park 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 20740 5005 Muskogee Street U.S.A. Funeral ral", or items 2 Examiner mur 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National Security Elementary/Secondary (0-12) College (1-4or 5+) the Civil Servant Agency (NSA) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jesse Huntley Ayer Mary Alice Angelico ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Heath an Important: If item 27 Is any injury or other trau once. 5005 Muskogee Street, College Park, MD 20740 Vickie Ayer, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Ammendale Cemetery 1/19/2008 Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Ave. ▶ Hyattsville, MD 20781 Gasch's Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction **Physician** /Medical Due to (or as a consequence of): Examiner Acute Cardial Arrythmia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Cardiogenick Shock and Due to (or as a consequence of) attending physician for use as the buria Diabetes Mellitus Physician/Medical 23c. If yes, outcome pf pregnancy
1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 21 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autop., performed: 2 No 2⊠ No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No 1 🔣 Inpatient 2 □ ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 1 🖾 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760

Saltimore, Maryland 21215-0036

after death filled in by 24 hours a

Medical within 24 State Registrar

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier som HU

D0013668

29c. License number

29d. Date signed (Month, Day, Year) -16-08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4917 Edgewood Rd., College Park, MD 20740 Azher Hussain, MD

31. Date filed (Month, Day, Year)

JAN 2 2 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** <u>10:</u>45 ам 1/20/2008 John Leo Augustine /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's 14997 Health Center Dr. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**⊠** M 2□ F Yrs. 90 225-10-0827 9/6/1917 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State th and Menial Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ∑Yes 2 □ No Director Bowie Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 14997 Health Center Dr. 20716 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 No If Yes, Give Year or Dates: 1 1 ☐ Never Married 2 ☑ Married 1934-1 ☐ Yes 2 ☒ No Specify: White 9 3 Widowed 4 Divorced 1946 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Self Employed Patent Researcher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John William Augustine Rosa Barkanda 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) nt of Health a : if item 27 is or other train 14997 Health Center Dr., Box 154, Bowie, MD 20716 Lucille Augustine, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 1/22/2008 Alexandria, VA 21. Signature of Funeral Service License 22. Name and Address of Facility 4739 Baltimore Avenue Casch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of)

Physician /Medical **Examiner**

1 and 2 should be filed within 72 hours after death with the Maryland

Pages '

Baltimore, Maryland 21215-0036

burial-tran attending physician for use as the buria Physician/Medical been signed by the should be detached þ Completed Be

The law requires that the death certificate be executed

25. Was case referred to medical examiner? 1 Yes 2 No

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p

Medical Certification: To 27. Manner of Death

Division or Vital Records, P.O. Box 68760,

State Registrar

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

4☐Pregnant at time of death 9□Unknown

3 ☐ Ectopic pregnancy 5 Other (specify)

Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Place of Death (Check only one)

Avenue # 231 Annapol 15

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

autopsy performe 1☐ Yes

2

28d. Describe how injury occurred

23d. Date of delivery

Month

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Day

Year

5 Pending investigation 6 ☐ Could not be determined.

28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient

2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 28b. Time of 28c. Injury at Work? Injury

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and tiple of certifier

29d. Date signed (Month, Day, Year) 01-21-08

30. Name an ladrice is of person who completed cause of death (Item 23a) (Type, Print)

hopra M.D.

31. Date filed (Month, Day, Ye JAN 2 2 2008

1 Natural

2 Accident

3□ Suicide

29a. Certifier

4 Homicide

(Check only one)

32. Registrar's Sign

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Wilhelmina Barbara Audesirk 17, 2008 1:08 January /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 1107 Lake Heron Drive, Apt. 1D Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 144-10-3682 1 □ M 2 1 P New Jersey 103 July 10, 1904 **Director** Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County wouls I 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Maryland Anne Arundel Annapolis 1 XYes 2 No Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21403 U.S.A. 1107 Lake Heron Drive, Apt. 1D Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant if item 27 is marked other than "natural", or ite sury or other traumante event, the Medical Examine ury or other traumante event, the Medical Examine 1 Never Married 2 ☐ Married 1 ☐ Yes 2XXXIII White Baltimore, Maryland 21215-0036 Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) International Firm Executive Secreatry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma Cecelia Clemens Joseph Conard Audesirk ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 103 Longwood Drive Groveville, New Jersey 08620 Charles J. Clemens, III/cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XX remation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or 1/20/2008 | Baltimore, Maryland Baltimore Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of uneral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Immediate Cause (Final **Physician** 1109 amorealic /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buris IF FFMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal de 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death Month Day in the past 12 months? 5 ☐ Other (specify) 4□Pregnant at time of death ed by the a detached f Yes 2 VAN 9 Unknown s been signed by a should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 21110 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 certificate has rector, page 2 performed 26. Place of Death Check onl one 25. Was case referred to medical Be examiner? Hospital: Other: 1 ☐ Yes 2 ☐ NO Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death.

To the Funeral Director: completely filled in by the 1 3☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🕒 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jun Blowe; MD.
31. Date filed (Month, Day, Year) JAN 2 2 2008 Registrar

			T = For State Registrar	State of M	aryland		artment <i>tificate</i>			and M	-	giene Reg. No.	800	032	33
	Dhuaisi		1. Decedent's Name (First, Middle, Las	t)							2. Date of Dea Month	ath Day	Year	3. Time of De	eath
	Physici /Medio		John A.	Austin							January			20:45	М
à	Examir	er	4a. Facility Name (If not institution, give	street and number)			-		Location o				ounty of Death		
			Fort Washington I						ashin					eorge's	
	Funeral		5. Social Security Number 6. Se	ex /.Ag [DM 2□F		ast birthday) Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day	y, Year)	Cou	place (State or F ntry)	
	Director		244-07-8323 Usual Residence of Decedent		86						Sept 12	2, 19	21 Nort	h Carol	ina
	yland st		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City	Limits
	Mar	tor	Maryland Prince (Goerge's	Su	ıitlan	d							Y⊖s 2	□ No
	ath with the Marylan 23a or 28a-f ahow unt be notified at	Director	10e. Street and Number				10f. Zip (Code				10g. Citize	n of What Cou	ntry?	
	23a c		2424 Fairhill Dri	ive			207	746				Unit	ed Stat	es	
	ams ams	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	S. 13. \	Was Decede	ent of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	- 14	Race - Ameri Black, White		
Š	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f ahow than "malical Examinar mual be notified at	Ϋ́E	1 Never Married 2 Married	1 XYes 2 If Yes, Give	No		1 ☐ Yes 2		Specify:		,			rican	
215-0036	ural',	d by	3√ Widowed 4 □ Divorced	Year or Dates:								101 16		rican	
င်	n 72	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		16a. Deced	ient's Usual kind of work DO NOT use	c done d	unng most	of working	g	160. Kind	d of Business/Ir	igustry	
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Ö	Hygi Hygi other ant,	Be C	17. Father's Name (First, Middle, Last)			COL	Lection	Juan			(First, Middle,			. L	
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Maryland	should land Meni		19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	g Address	(Street a	nd Numbe	or Aurai	Route Numbe	er, City or	Town, State, Zi	o Code)	
	and 2 Balth a n 27 is		John R. Austin -	Son	ve-assauni	2424	Fairl	nill	Driv	re Su	itland,	, MD	20746		
altimore,	- I 9 =	1	20a. Method of Disposition	Dameual from State	20b. Pla	ace of Dispo	sition (Nam-	e of her place	9)	D	ate	20c. Loca	ation - City or T	own, State	
Ĕ	Pages ment of tant: If It lury or o		1 SpBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			yland				/31/08	3		Che1	tenham,	MD
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			23a. Part1. Enter the disease, or comp show or heart failure. List only	olications that caused one cause on each Ji	d the death. ine.	. Do not ent	er the mode	of dying	, such as	cardiac or	respiratory ar	rrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	CV	1									Onset and De	A
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):								0	
	LAUMMICI		Sequentially list conditions,	b.		5	4							dant	7
	ed isit	iner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a so isaqu	enca oty.	T							dout	
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200	certificate Iding phys			0.			7	•							
X Q Q	leath certifica ettending ph I for use as th	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			· ·					23	d. Date of deliv	ery	
	death e etten ed for u	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 4☐Pregnant a			Ectopic pre Other (spe						Month	Day Ye	ar
r Ö	the the	Physician/Med	9 Unknown	9□ Unknown											
	law requires that the de as been signed by the 2 should be detached	by F	Part II. Other significant conditions co	ontributing to death b	out not resu	Iting in the u	nderlying ca	use give	n in Part I.		23e. Did to	obacco us	e contribute to	the cause of dea	ath?
cords,	equir en si ould										101	Yes 2□	No 3∏Pro	babiy 4 <u>y</u> E∏Uni	known
ပ္သ	25 8	ple									24a. Was	an	24b. Were aut	opsy findings av empletion of cau	ailable
r =	Page 1	Completed										rmed? 2 No	death? 1 ☐ Yes	2□ No	
/Ital	ysician: Th iis certificete director, pag	Be	25. Was case referred to medical examiner?					Lou		of Death	(Check only o	ne)			
ö	Phys this aldi	2	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Copation		ER/Outpatien			4 🗆 140.				Other (Spec	fy)	
	Attending Physician: r death. setor: After this certific by the funeral director.	ertification;	1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ly Year)	28b. Time of Injury	M 28	C. Injury Work	at ? ′es 2∐t		8d. Describe i	now injury	occurred		
VISION	Attendii death. ctor: A y the fu	ical	2 Accident investigation 3 Suicide 6 Could not be		iury - At hor	me farm str			63 2 🗆 1		8f. Location (5	Street and	Number or Ru	al Route Numbe	91
2	in Life	erti	4 Homicide determined	building, et	c. (Specify))	001, 1401017,	011100			City or Tov	vri, State)			
	Hospital 14 hours a Funeral i tely filled	aic	29a. Certifier Certifying Ph	ysician: To the best	of my know	vledge, death	occurred a	t the tim	e, date and	d place, a	nd due to the	cause(s) a	nd manner as	stated.	
	the Ho hin 24 i the Fu mpletely	edicai	(Check only 2 Medical Examone)	iner: On the basis o and manner st	it examinati	ion and/or in	estigation,	in my op	inion, deal	th occurre	d at the time,	date and p	lace, and due	to the cause(s)	
	To the To the Comp	Ž	29b. Signature and title of certifier	100		71111	290	License	number	,	10	29d. Date	stigned (Morith		رسي
)			M.M. A	Telet	a	N DW	1) (>0-C	+6	046	1/	191	299	X
_ /	(2)		30. Name and address of person who o	completed cause of o	death (Item	23a) (Type,	Print)					- /			
1	N		Amir Mirza-Alkha				Rd Ft	. W	ashin	gton	, MD				
	Sta Registr		JAN 2 3 2008	32. Registr	rar's Sign (ure									
30	- region	110	OTHER OF THE	- A - A - A - A - A - A - A - A - A - A	4										

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	ryiand		rtment of I tificate of		ınd Me	ntal Hyو	giene Reg. No.(2008	03234
¥			Decedent's Name (First, Middle, Last	st)					2	. Date of Dea	ath		3. Time of Death
	Physicia /Medic	_	Rhea Joyce A	dams					J	Month anuar	Day y 17		05:32 AM
	Examin	40.00	4a. Facility Name (If not institution, give				4b. City, Town,	or Location of	f Death		4c. (County of Death	
	\$\frac{1}{2}	8	Union Hospital o				E1kto					Ceci1	
	Funeral		5. Social Security Number 6. S 218-26-7249	ex 7. Age □M 2X F		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birt (Month, Da	y, Year)	Cou	
	Director		Usual Residence of Decedent		78				S	ept.	22,	1929 Mar	yland
	yland iow		10a. State 10b. County		10c. City,	Town or Loc	cation						10d. Inside City Limits
	Mar St.	ior	Maryland Cecil		No	rth Ea	ast						1 □Yes 2 No
	or 28	Funeral Director	10e. Street and Number				10f. Zip Code		-		10g. Citiz	en of What Cou	ntry?
	23a ust b	al	57 Falls Road				2190	1			Unit	ted Stat	es
	tems term	nue	11. Marital Status	12. Was Decedent En		6. 13. V	Vas Decedent of Yes, specify Cub	Hispanic Orig	gin? (Specif , Puerto Ric	y Yes or No- can, etc.)	- 1	 Race - Ameri Black, White 	
30	72 hours after death with the Maryland natural", or Items 23a or 28a-f show lical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2\(\)\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\)	1	☐ Yes 2☐XNo	Specify:				Specify: Wh	ite
2-003e	hour tural		15. Decedent's Ed		1	16a. Deced	ent's Usual Occu	pation			16h. Kir	nd of Business/Ir	
5	n "ng Medic	Completed	(Specify only highest gra	de completed) College (1-4or 5+		(Give I	kind of work done OO NOT use retire	during most	of working		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		,
7	d with giene gr tha the I	E O	12	College (1-40r 5+	'	Ca	shier					Retail	
and	al Hy othe	Be	17. Father's Name (First, Middle, Last)					18. Mother	r's Name (F	First, Middle,	Maiden :	Surname)	
la.	Menta	10	Richard Borden					Kat	h1een	Ho11	ister	:	
Mar	2 sho and sum		19a. Informant's Name/Relationship (Type. Print)			g Address (Stree						
a` o`	l and lealth im 27 her ti		Lorie Arrants / Da	aughter	DOL DI		rants Re						1901
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural!" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		1		sition (Name of natory or other pla	1	anuar	У	20c. Lo	cation - City or T	own, State
Бантшог	it. Partmentant		4 □ Donation 5 □ Other (Specification 21. Signature of Juneral Service Licer		Nor		t Method						Maryland
0	Depa Impo any i		21. Signature of Funeral Service Picer	isee			Name and Addr						ryland21901
-	- J =		23a. Part1. Enter the disease, or com	plications that caused t	he death.							ast, Ma	Approximate
	Dhysisian		shock, or heart failure. List only Immediate Cause (Final	one cause on each line									Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a		ence of):	· / · / · /	1-1400	· C //	0/0			unknown
	Examiner			(PX	01/	MRY	· IN	12004	1	D 58	ASE	-	
Q t		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequ	ence of):	Y						
	ecuted nd transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c									
Ď,	sian a	Ě	resulting in death) cast	Due to (or as a	consequ	ence of):							
00/00	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the bunal-transit	edical	•	d						-			
×	ding se as		IF FEMALE:	23c. If yes, outcome p	f pregnar	ncv						204 0-4-44-15	
א ס	atten for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal	death 3	Ectopic pregnand Other (specify)	у			12	23d. Date of delive Month	very Day Year
	the d y the iched	ysi	1 ☐ Yes 2 ☐ Wo 9 ☐ Unknown	9□Unknown	inc or do								
7	w requires that the death certific been signed by the attending p should be detached for use as	by Pt	Part II. Other significant conditions	contributing to death but	not resul	Iting in the un	derlying cause gi	ven in Part I.		23e. Did t	obacco u	se contribute to	the cause of death?
cords,	quire an sig uld bi									1 🗆 '	Yes 2	⊒ł¶o 3□ Pro	bably 4 Unknown
ည သ	aw re	Completed								24a. Was		24b. Were aut	opsy findings available
Ĕ	The late has	E								autor perfo 1 Yes	psy ormed? 2 No	prior to co death? 1 ☐ Yes	ompletion of cause of 2E2 No
D.	lan: rtifica	BeC	25. Was case referred to medical					26. Place	of Death (Check only o	_ <u> </u>	1 100	26110
>	nysic nis ce I direc	은	examiner? 1 Yes 2 V	Hospital:	t 2 🗆 E	R/Outpatien	t 3□ DOA Ot	her: 4 🗆 Nur	rsing Home	5 ☐ Resi	dence 6	6 □Other (Spec	ify)
5	ng Pl		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury	28c. Inju	iry at ork?	28	d. Describe	how injur	y occurred	
202	tendl eath. tor: A the fu	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Codid not be					Yes 2 1					
<u> </u>	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or	Certification:	4 ☐ Homicide determined	28e. Place of injur building, etc.	y - At hor (Specify)	me, farm, stre	eet, factory, office		28	f. Location (a City or To			ral Route Number,
_	prital		29a. Certifier 1 ertifying Ph	yslcian: To the best of	my knov	vledge death	occurred at the	time date and	d place an	d due to the	cause(s)	and manner as	etated
	e Hos 24 h e Fur letely	Medical	(Check only 2 ☐ Medical Examone)	niner: On the basis of and manner stat	examinati	ion and/or inv	estigation, in my	opinion, dea	th occurred	at the time,	, date and	place, and due	to the cause(s)
	To th Within To th	Me	29b. Signature and title of certifier	11			29c. Licen	se number			29d. Daj	e signed (Month	Day, Year)
			1 Much V	4/5	M	7.	DC	2051	195	3	1/1	18/08	
	12		30 Name and address of person who	completed cause of de	ath (Item	23a) (Type, I	Print) ///	W.	16'0	261	5-1	-	0:001
	1~		KAKAON VA	DO JAN	PM	AV,	, ,,	1.	ELK	100		MD	21921,
			31. Date filed (Month, Day, Year)	32. Registra	: .	/		Section 1			7		

DHMH 17 Rev 1/2001

For State

State of Maryland / Department of Health and Me

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	■ Registrar	
	1. Decedent's Name (First, Middle, Last)	
Physician		
/Medical	Shirley Edna Allender	
-	4a Facility Name (If not institution, give street and number)	

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funaral Director: After this certificate has been signed by the attending physician and

Division or Vital Records, P.O. Box 68760,

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ion	1. Decedent's Na	ne (First, Midd	dle, Last)											Van		of Death
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ner	4a. Facility Name	Shirley Fdna Allender 4a. Facility Name (If not institution, give street and number)						Fown, or	Location	of Death	Odi	QCD_ y	_			
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	218-28-0	1976	1 □ M 2 🔯 i	F	87	Yrs.	Months	Days	Hours	Min.				- '	Country) M	D
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	10a. State	10b. County	у		10c. City,	Town or Lo	cation								10d. Inside	City Lim
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ပိ	17. Father's Name	o / Eirot Adidello	, / anth				попел	aker		M.	/F: ·				.e	
Be	_						-			ırname)						
ြို	George (Edna May Elwell												
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	Richard	d Allen	ore-	-Anna	Ботт	S BI	.va :	sever	na Pa	ack, MD	21					
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To Be Completed by Funeral Director	21. Signature of												apel	- P.A		
	Man	lo De	4										_	•		57
	shock, or heart failure. List only one cause on each line.												Between			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2008 10,50 am ALEXANDER MORRIS WINSTON Januar 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mato dical 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1⊠M 2□F Months 87 12,1920 218-38-9056 JUNE MARÝLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2€No CHARLES COBB ISLAND MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 16526 OAKLEY DRIVE 20625 U. S. A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Amed Folces. 1 Ves 2 No If Yes, Give Year or Dates: W.W.II 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify. 3 ☐ Widowed 4☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 U. S. GOV'T. PIPEFITTER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM H. ALEXANDER OVA MYRTLE KINCHELOE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #6 FIRST ST. INDIAN HEAD, MD 20640 MARY ANN ALEXANDER/FRIEND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State JANUARY 12, 2008 4 □ Donation 5 Other (Specify) METROPOLITAN CR. ALEXANDRIA, VA 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 21. Signature of Funeral Service J 5635 WASHINGTON AVE. LA PLATA, MD 20646 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) Oron m Due per or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) Yes 2 No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of _eath 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Physician /Medical Examiner Examiner The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

items 23a or 28a-f show ner must be notified at

item 27 Is marked other than "natural", or item other traumatic event, the Medical Examiner is

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Health a

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Department c Important: if any injury or

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Pages 1 and 2 should be

Director

by Funeral

Be Completed

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with the Maryland

filed within 72 hours after death

Maryland

P.O. Box 68760.

Division or Vital Records.

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Hospital or Attending

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> physiclan and s the burial-trans as the attending use for should be detached signed by has page 2 certificate funeral director, this / fter death. within 24 hours at er death To the Funeral Director: filled in by

Physician/Medical

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Certification: To

Medical

29a. Certifiei

one)

(Check only

29b. Signature and title of certifier

State

Registrar

completely

29d. Date signed (Month, Day, Year)

JANUARY 31, 2008

3-. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Center 701 East Charles St. La Plata, MD 20646 Health steden 31. Date filed (Month, Day, Year)

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year Physician P January 11, 2008 2:16 Ρ. /Medical Ellen Bailey 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's 14900 Fir Street Accokeek If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 □ ₹ Director Dec. 23, 1920 Washington, DC 87 577-24-2849 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medi al Examiner must be notified at 1 TYes 2 □ No Director Maryland Prince George's Accokeek 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 14900 Fir Street 20607 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 XNo African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify ģ 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 years Elevator Operator Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill Health and Mental H tem 27 is marked oth Be James R. Early Elnathan Mitchell ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau Bryan W. Tate, Sr. - Grandson 14900 Fir Street Accokeek, MD 20607 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Harmony Mem. Park Jan 19, 2008 Landover, MD 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Sig a vre of Funeral Service Lice 4001 Benning Road, NE Washington, DC 20019 23a. Part1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Weeks Immediate Cause (Final disease or condition resulting in death) Metastatic Carcinoma of Unknown Origin Physician /Medical Due to (or as a consequence of) Examiner Diabetes Mellitus Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-transit death certificate be executed and Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed? certificate ! 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 🎇 Residence 6 ☐ Other (Specify) 1 Yes 2 No e 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA After this funeral (28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After ti Certification: 5 Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) To the I within 24 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 17, 2008 D0046046 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Amir Mirza Alikhani, M.D. 101 Centennial St., Suite B LaPlata, MD 20646-1890 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State JAN 2 2 2008 Registrar

DHMH 17 Rev 1/2001

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			State Registrar			Cer	tificate of I	Death		neg. 110.= -					
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Box	death certific attending p	an/I	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	tcome pf pregnar pirth 2 ☐ Fetal	death 3[Ectopic pregnancy	/		23d. Date Mor	e of delivery oth D	/ Day Yea	ar		
0	The law requires that the death certific tte has been signed by the attending page 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 █ No 9 ☐ Unknown	4∐Pregr 9□Unkn	nant at time of de own	ath 5	Other (specify) _					•			
Δ.	res that the signed by be detaction		Part II. Other significant condition	ons contributing to de	eath but not resu	Iting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use contri	ibute to the	oute to the cause of death?			
Records,	uires sign Id be	d by	End Sta	pe len	al 13	useu	PAR		1 🗆	Yes 2 No	3 Probab	bly 4 ⊒trik	known		
2	w requir s been si should	Completed	Diabetes	: Mel	lites				24a. Was	an 24b. V	Vere autops	sy findings ava	ailable		
	The la te has age 2	ошр	Dement	ia (2 oneh	~1 i	nfarc	500	perf	ormed? d	leath?	pletion of caus □ No	se or		
Vital		Be C	25. Was case referred to medica examiner?		200-07		V C / W · C	26. Place of Dea							
	hyslc his ce I direc	To E	1 Yes 2 No	Hospital: 1	Inpatient 2 🗆 E	ER/Outpatier	t 3□ DOA Oth	4€ Nursing ⊓	ome 5 Res	idence 6 □Othe	er (Specify)				
ם	Attending Physician: The lav r death. ector: After this certificate has by the funeral director, page 2		27. Manner of Death 1 □ Natural 5 □ Pendir	ig .	of Injury th, Day Year)	28b. Time o Injury	Wor		28d. Describe	how injury occurre	ed				
<u>s</u>	r Attend er death. rector: / by the f	cati	2 Accident investig	not be 280 Place	of injury - At ho	me farm str	M 1 □ reet, factory, office	Yes 2 □ No	28f Location	(Street and Numbe	er or Rural F	Route Numbe	or .		
Division or	I or Attendafter death Director: I in by the	Certification:	4 ☐ Homicide determ	ined build	ing, etc. (Specify)	cot, lactory, office		City or To	wn, State)	er or marari	70dic 74dilloc	,,,		
	e Hospital of 24 hours at e Funeral Dietely filled i			ng Physician: To the											
	To the Hospital or A within 24 hours after To the Funeral Direction population of the formal completely filled in by	Medical	one)		ner stated.	ion and/or in	29c. Licens		irred at the time						
	viti To	2	29b. Signature and title of certifie	00.	1. 11	0			2	29d. Date signed			67		
	(10)		30. Name and address of person	who coppleted care	se of death (Item	23a) (Type	Print)			4-4,46/4		3, 20,			
R			PAUL A. D	dopped l	40 42	0301	reensb	ory Rd	Hyat	130,1/e	MID	100	51		
Ą	Sta		31. Date filed (Month, Day, Year)	_	Registrar's Signal	ture									
	Registi	ar	JAN 2 2 2008	Deleve		The same									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Brown, Sr. 0500 A. M Raymond 2008 January 17, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Takoma Park Montgomery Washington Adventist Hospital 8. Date of Birth (Month, Day, Year) 1933 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday, 5. Social Security Number 6. Sex **Funeral** Days Months Hours Min. 1 X M 2 □ F 74 North Carolina November 24, 243-50-7409 Director Usual Residence of Decedent ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County sa or 28a-f show t be notified at 1XYes 2 No District of Columbia Washington Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United STates 20018 3124 Chestnut Street, N. E. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 \(\subseteq \text{No US Army} \) Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items Black, White, etc. 1 ☐ Never Married 2 ☐ Married **Black** Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Marriott Corporation Tele Communication Worker 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tessie Graham Joseph Brown မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3124 Chestnut Street, N.E.; Washington, D.C. 20018 Chrishena D. Brown (Daughter) Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Iter
any Injury or ott
once, Jan.26,2008 1 Burial 2 □ Cremation 3 □ Removal from State Kinston, North Carolina Pinelawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Synature of uneral Service K. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. Dano 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) O Can **Physician** /Medical Due to (cr as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed as the burial-tran and Box 68760 nding physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy Por Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? s certificate has b lirector, page 2 s 1 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Tes 2 No 1 Inpatient this funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? Certification: al or Attending F After (Month, Day Year) 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Takoma Pank, MD 20912 31. Date filed (Month, Day, Yea State **JAN 2 2**

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Physician 6:56P M JANUARY CLAUDIA ANN2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F Yrs. Director 578-56-4698 SEPT. 10 1941 WASHINGTON, DC 66 Usual Residence of Decedent with the Maryland 10d, Inside City Limits 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Directo PRINCE GEORGE'S MD UPPER MARLBORO 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or USA permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must any Injury or other traumatic event, the Medical Examiner must 403 PEMBERTON STREET 20774 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: BLACK þ 3 ☐ Widowed 4 ▼ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 5+ COMPUTER ANALYST GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FESCO WILLIS CARRIE DAVIS ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JULLIAN BREVARD/SON 3543 SOUTH PRAIRIE UNIT 2S CHICAGO, ILL. 60653 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 1/23/2008 CLINTON, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BILATERAL PLEURAL EFFUSION **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner METASTATIC BREAST CANCER Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No 24a. Was an autopsy has certificate 2 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To nours after death.

neral Director: After this
filled in by the funeral d 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001

Registrar DHMH 17 Rev 1/2001

State

Donald

31. Date filed (Month, Day, Year)

JAN 2 2 2008

HOSDITA

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Jan. 18 Day 2008 Year 0649 Bentillo **Physician** G. Israel /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Cheverly Prince Georges Hospital 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1√ M 2 □ F March 17 1951 Phillipines 56 None Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1√EYes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified a once. Director Maryland Prince Georges Largo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Phillipines 20774 611 Harry S. Truman Dr. #101 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ă No If Yes, Give Year or Dates: 11. Marital Status Black, Whitelespino 1 Never Married Married 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Univ. Of The Phillipines Professor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Felicisima Gemperoso Santiago Bentillo 19a Informant's Name/Relationship (Type. Print) Eulalia N. Bentillo (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 611 Harry S. Truman Dr. #101 Largo, MD 20774 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hesapeake Crematory 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/26.2008 Beltsville, MD 4 □ Donation 5 □ Other (Specify) Rendon/Hale Fineral Home 22. Name and Address of Facility 21. Signature Funeral Service Licensee 9013 Annapolis Rd. Lanham, MD 20706 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (pr as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse uence of) Physician/Medical Examiner Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 menths? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2⊡No 1 ☐ Yes 2 □ No 1☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manper of Death Injury 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide determined 4 Homicide 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated.

the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Division or Vital Records, P.O. Box 68760, physician attending ph for use as t signed by the a cate has t , page 2 s certificate After this in 24 hours area.
the Funeral Director; Af

show

Baltimore, Maryland 21215-0036

within 24

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 2 2 2008

3001 HOSPITAL Drive 32. Registrar's Signature

30. Name and address of roon who completed cause of death (Item 23a) (Type, Rrint)

29c. License number

29d. Date signed (Month, Day, Year)

Chererly MD 20785

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** P^{M} Philip Kane Brown 17, 7:30 2008 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 5 Tiburon Court Annapolis | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Hours | Min. | July 15, 19 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral 1**5 M 2 □ F Yrs. 223-52-6909 65 1942 Vírginia Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar arment of Health and Mental Hygiene. Ordent: If Item 27 is marked other than "natural", or items 23a or 28a-f show ortant: If Item 27 is marked other than "natural", or items 25a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Anne Arundel Annapolis 1XX es 2 No Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 5 Tiburon Court 21403 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No
If Yes, Give 1959–63
Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Executive Television 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Philip Brown Virginia Scahill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Louise Coleman-Brown/wife 5 Tiburon Court Annapolis, Maryland 21403 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Department o Important: If any injury or once, 1/19/2008 Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Sequice Licensee rodd 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARRHYTHMIA MINUTES **Physician** /Medical Due to (or as a consequence of): Examiner DISEASE YEARS L'ERONAKY ARTERY Sequentially list conditions, in any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Jue to (or as a nonsequence of) Examiner requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as IF FEMALE: esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably APIVEA DIABETES Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s performed Yes 2 1∐ Yes funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? After Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

ne Funeral Director: A pletely filled in by the fu death. 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertition 01/18/08 humala MD D47311 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Suzanne Niemela, MD 205 Ridgely Avenue Annapolis, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 2 2008 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Physicia /Medic Examine **Funeral**

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any finity or other traumatic event, the Medical Examinar miss because once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician; The law requires that the death certificate be executed is certificate has been signed by the attending director, page 2 should be detached for use as

Division or Vital Records, P.O. Box 68760,

	T = State Registrar	Cer	tificate of	Death	F	Reg. No. 2008 032					
	Decedent's Name (First, Middle, Last)				2. Date of Dea			3. Time of Death			
n	Daisy Leona Bass				January	17^{Day}	2008 ^r	02:30 P M			
ii r	4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	or Location of Deat			County of Death				
•	Crofton Convalescent & Rehab, Center		Crofton			An	ne Arun	del			
Ť	Social Security Number	s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	n	9. Birthr	place (State or Foreign			
	246-62-3939 1□M 2DF 88	Yrs.	Months Days	Hours Min.			Couit	ntrv)			
	Usual Residence of Decedent	!		1	05/11/1	1717	NOT CIT	Caronna			
		City, Town or Lo	cation					I0d. Inside City Limits			
ō	Maryland Anne Arundel E	dgewate	r					1 □ Yes 2 X No			
ဥ	10e Street and Number		10f. Zip Code			10a Citiz	en of What Cour	ntn/2			
Completed by Funeral Director				- 7		_					
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Š	Armed Forces?	U.S. 13. V	f Yes, specify Cub	Hispanic Origin? (S ean, Mexican, Puer	ipecity Yes or No- to Rican, etc.)	'					
Σ	I If Yes, Give	1	I∐Yes 2 X ∏No	Specify:			Specify: Whi	te			
Ö	11										
ete	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occu kind of work done	pation during most of world)	rking	16b. Kin	d of Business/In	dustry			
ᄅ	Elementary/Secondary (0-12) College (1-4or 5+)			rd)							
3		Home	maker	1							
e n				l		Maiden S	Surname)				
0	Preston Godwin			Celia H	Bass						
- 5	19a. Informant's Name/Relationship (Type. Print)										
	Florence Ingram/Daughter	1018	01d Turk	ey Point	Road, Ed	lgewa	iter, Ma	ryland 210			
		. Place of Dispos	sition (Name of natory or other pla	(22)	Date	20c. Loc	ation - City or To	own, State			
	1 Denotion 5 Other (Specify)	las Crei	, ,	· '	19/2008	Edac	water	Maryland			
	21. O'gradid Strate Licenses										
	July 1. Mells						<i>i</i> ater, M				
	sneck, of heart failure. List only one cause on each line.					Anne Arundel Secondary Anne Arundel Anne Arundel Secondary Secondary Anne Arundel Anne Arundel Anne Arundel Secondary Anne Arundel Anne Arund	Approximate Interval Between				
	Daisy Leona Bass 4a. Facility Name (If not institution, give street and number) Crofton Convalescent & Rehab. Center 5. Social Security Number 246–62–3939 Usual Residence of Decedent 10a. State 10b. County Maryland Anne Arundel 10c. Ci Maryland Anne Arundel 11. Marital Status 1	luotic	Coudi	o Valan	las D	Vec	lat	Onset and Death			
	resulting in death) Due to (or as a conse	equence of):				0		geas			
	Demen	atia						1-Pan 0			
Je l	if any, leading to immediate Cause Enter Underlying Due to (or as a conse	equence of):						J CC3.			
	Cause (Disease or injury										
Ехашпе	requiting in death) Leat	equence of):									
	d										
Medical	u										
	IF FEMALE: 23c, If yes, outcome pf pred	nancv				200	2d Date of deliv				
Cla	in the past 12 months?		Ectopic pregnanc Other (specify) _	У							
2		rueam 5_	Other (specily) _								
E		soulting in the un	dorbing souss si	on in Dart I	22a Did to		o contribute to t	be some of double?			
2	Fact it. Other significant conditions contributing to death but not te	esulting in the un	idenying cause giv	ven in Part I.			_				
nene					1 L Y	es 2x	No 3 Prot	oably 4 □Unknown			
					24a. Was a	an	24b. Were auto	psy findings available			
I I					perfor	'm <u>ed</u> ?	death?				
ט	25. Was case referred to medical			26 Place of Dec	1 Yes ath (Check only or	\sim	I LI TES	es 2LINO			
0	examiner?	☐ ER/Outpatient	t 3 DOA Oth				□0±1- (0 ±				
		28b. Time of						y)			
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2	3 Suicide 6 Could not be Ose Blees of injury. At	home form stre			005 1 10						
≣	determined 20e. Place of injury - At	nome, rarm, stre cify)	eet, factory, office		Cify or Tow	treet and n, State)	Number or Rura	al Route Number,			
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200	(Check only 2 Medical Examiner: On the basis of exami	nowledge, death nation and/or inv	occurred at the ti	me, date and place	e, and due to the d	cause(s) a	and manner as s	tated.			
ב <u>ק</u>	one) and manner stated.				and at the time, t	acto una	piace, and age t	o trie dadde(d)			
2	29b. Signature and title of certifier		29c. Licens		0	29d. Date					
	Kakosh anno	MD	D	2010	8	01	118/0	8			
-	30. Name and address of person who completed cause of death (Its	em 23a) (Tvne									
	RAKESH ARORA MD 143	ROGA	LLANT	FOXLA	1 BOW	E	MDZ	0817			
,	31. Date filed (Month, Day, Year) 32. Pegistrar's Sig	nature			/			-			
	JAN 2 2 2008	4 1									
	J. Guille	15 6	cells)								

State Registrar

State of Maryland / Department of Health and Mental Hygiene () (1) (2)

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			1 - State Registrar		,	Certifica	te of i	Death	R.	eg. No.	000	UJ	44	
75	Div. in		1. Decedent's Name (First, Middle, La	ast)		-			Date of Deat Month		V	3. Time o	f Death	
k	Physici /Medi		Virginia Ruth Br	umm						/2008	Year	3:3	35pm ^M	
	Examir	ner	4a. Facility Name (If not institution, given					Location of Deat	h	4c. Co	unty of Death			
	ing the second s		Anne Arundel Medi				nnapo er 1 Year				Arund			
w ²	Funeral Director		-	Sex 7. Ag 1 ☐ M 2 🛣 F	ge (In yrs. last birt	rs. Months		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 5/20/1	Year) 927	9. Birthp Coun	lace (State try) Ohio	0	
	yland now		10a. State 10b. County	1.1	10c. City, Town						1	0d. Inside C	ity Limits	
	a-f st	ctor	MD Anne A	rundel	Cro	ofton					1 □ Yes 2X No			
	th the or 28 e not	Jie.	10e. Street and Number			10f. Z	ip Code		1	0g. Citizen	itizen of What Country?			
	ath w 23a ust b	<u>ra</u>	1703 Fernham Ct.				211				USA			
36	be filed within 72 hours after death with the Maryland ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2□ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent Armed Forces? 1 Yes 25 If Yes, Give Year or Dates:	•			ispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)		Race - Americ Black, White, ecify: Wi			
9	2 hou atura cal E	ted	15. Decedent's E	ducation	16a.	Decedent's Us	ual Occup	ation		16b. Kind d	of Business/Inc	lustry		
Maryland 21215-0036	e filed within 72 al Hygiene. I other than "ni vent, the Medi	Completed	(Specify only highest gr Elementary/Secondary (0-12) 12	ade completed) College (1-4or	5+)	(Give kind of w life. DO NOT Homem	use retired	during most of wo	rking	Own		,		
d 2	filed Hygi ther nt, t		17. Father's Name (First, Middle, Las	")		nomem	IRCI	18. Mother's Nar	me (First, Middle, M					
lan	should be not all marked or marked o	To Be	Louis Shaffer					Mary Cr	emans					
ary		-	19a. Informant's Name/Relationship	(Type. Print)	19b.	Mailing Addres	s (Street	and Number or Ri	ural Route Number	City or To	wn, State, Zip	Code)		
Σ	1 and 2 Health a tem 27 is		Robert Brumm So	n	48	394 Sol	omons	Island	Rd. Har	wood.	MD 20	776		
ore	Se to I		20a. Method of Disposition 1 ☐ Burial 2√√Cremation 3 [Domovol from State	20b. Place of cemeter	Disposition (Na y, crematory or	ame of other plac	e)			on - City or To			
<u><u>Ĕ</u></u>	Pag ment ant: I		4 □ Donation 5 □ Other (Speci		Metro (Cremato:	ry	1/22	2/2008 B	altim	ore, M)		
Baltimore,	permit. Page Department of Important: If any Injury of once.		21. Signature of Funeral Service Lice	nsee	•				rdesty F			, P.A.		
	₫ D E 8 0		18 g. G	_		1			nnapolis		21041			
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that cause one cause on each li	d the death. Do ne.	of enter the mo	de of dyin	g, such as cardia	c or respiratory arre	est,		Approxima Interval Be Onset and	tween	
No.	Physician		Immediate Cause (Final disease or condition resulting in death)											
	/Medical Examiner		Sequentially list conditions b											
		ē												
	uted I Insit	Ë	Sequentially list conditions, if any, leading to find additional cause. Enter Underlying Cause (Disease or injury that leither and the conditions of the con											
,	execting and and ial-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of	rf):								
68760,	icate be executed physician and the burial-transit													
9	The law requires that the death certificate be executed te has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Medical	IF FFMM F											
Box	eath cer attendir for use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth	pf pregnancy 2 Fetal death	3 □Ectopic	oregnancy	,		23d.	Date of delive		Vee	
	ed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant a		5 ☐ Other (Month	Day	Year	
P.0	w requires that the d been signed by the should be detached	Physician/	9 Unknown			dia a contrata de de con			OO- Distant				ala ash O	
	res th signed be d	by	Part II. Other significant conditions	contributing to death r	out not resulting in	tne underlying	cause givi	en in Part I.		. /	contribute to the			
orc	requi	ted							1 □ Y€	es ZZN	10 3 P100	ably 4 □	UTIKHOWIT	
Sec.	e law has b je 2 sl	lgi							24a. Was a autops	y /	 Were auto prior to cor 	psy findings npletion of c	available cause of	
al F	(0 (1	Completed							perform 1□ Yes	No No	death? 1 ☐ Yes	2□ No		
or Vital Records,	Physician: r this certificanal director, is	Be	25. Was case referred to medical examiner?	Hospital:			Oth	er.	ath <i>(Check only on</i>					
ō	Phys rthis raldi	۲: ا	1 Yes 2 Mo 27. Manner of Death	1 Inpati			OA	4 LI Nursing F	tome 5 ☐ Reside			v)		
on	ding h. After fune	iol	1 ■ Natural 5 □ Pending	(Month, Da	y Year) Ir	njury M	28c. Injur Worl	k? Yes 2 ☐ No	200. 2000.20 110	on injury oc	Journed			
Division	Attending r death. ector: After by the fune	fica	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined determined 28e. Place of injury At home, farm, street, factory, office 28f. Location (Street)								umber or Rura	l Route Nur	mber,	
言	after after of in b	Certification:	4 ☐ Homicide determined	building, e	tc. (Specify)				City or Towr	n, State)				
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying P (Check only one)	hysician: To the best miner: On the basis of and manner si	of examination and	, death occurre d/or investigation	d at the tir	ne, date and place	e, and due to the curred at the time, d	ause(s) and late and pla	d manner as s ace, and due to	tated. the cause	(s)	
\	To the within 2 To the comple	Me	29b. Signature and title of certifier	Dinati	mn	2	9c. Licens	e number	145	9d. Date si	igned (Mghth,	Day, Year)		
	2.A	\mathcal{L}	20 Name and Oldinas - frame	completed course	dooth (Harrison 10	Dana Dáirtí	100	000	1	1/-	1	- 0		
	11/00		30. Name and address of person who	anglein	6 0C/	type, Print)	17	14) t	In spel	15/	חח			
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 2		rar's Signature		•	-	*					
DH	IMH 17 Rev 1/2		JHIV & &	2000	wa G	Spen								

State Registrar 31. Date filed (Month, Day, Year) **JAN 2 2** 2008

29a. Certifier

(Check only one)

29b. Signature and itle of certifier

Mirza M. Nusairee, M.D. 1667 Crofton Centre, Suite 1 Crofton, MD 21114 32. Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Bobby Januar Owens Beach /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner swy icomico Regional If Under 1 Year | If Under 24 Hi 8. Date of Birth (Month, Day, Year) . Social Security Number 7. Age (In yrs. last birthday 6. Sex **Funeral** Months Days Hours 1 X M 2 □ F 77 12/22/1930 Delaware Director 220-26-2088 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 TXYes 2 □ No Director Wicomico Salisbury Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 423 Parkwood Drive 21804 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give 11 Marital Status Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 2 X No Specify: white ò 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 accountant accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sadie Owens Otho Beach 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 423 Parkwood Dr., Salisbury, MD 21804 Anne D. Beach/wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/23/08 4 Donation 5 Other (Specify Hebron Cemetery Hebron, MD The and Address of Facility 1 H L Snow HIII Rd., 21. Signature of Funeral Service Livense Home Professional Association , Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ORUNATE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a nunseattence of Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): physician a Box 68760, Physician/Medical attending phase as t IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day in the past 12 months? ☐Yes 2☐No Division or Vital Records, P.O. been signed by the should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 autopsy performed? Yes 2 1 No 1 certificate Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl o e Be Other: 1 ☐ Yes 2**X** No 2 ☐ ER/Outpatient 3X DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient ٩ this 27. Mariner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred After ! Certification: (Month, Day Year, Iniury 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and titlerof certifier 30. Name and/address of person who completed cause of death (Item 23a) (Type/Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 2008 Registrar

2836

State of Maryland / Department of Health and Mental Hygiene Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 18,2008 Month **Physician** Brooks 8:44 a M Connell Elmer January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince Georges 8. Date of Birth (Month, Day, Year) 12/24/1963 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 6. Sex **Funeral** Months Days Hours 1 X M 2 □ F Yrs 44 **Director** 577-04-5330 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits show 3a or 28a-f show t be notified at 1 XIYes 2 □ No Director Maryland Prince Georges Suitland 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 23a or USA 3414 Navy Day Drive 20746 "natural", or Items 23a within 72 hours after death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black þ 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important; if Item 27 Is marked other the any injury or other traumatic event, the once. the Driver 12 Shenger 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martha Maria Washington Thomas Elmer Brooks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3414 Navy Day Dr. Suitland, Maryland 20746</u> <u>Christine King/ Sister</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Clinton, Maryland 4 Donation 5 Dother (Specify) Resurrection 1/26/08 21. Signature of Fune at Service Lice 22. Name and Address of Facility Adams Funeral Home PA 20605 Aquasco Rd. Aquasco, Maryland 20608 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MYOCARDIAL INFARCTION Physician A CUTE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed and burial-trai Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a ☐ Yes 2☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, ESOPHAGENZ CARCINOMA 1 Yes 2 No 3 Probably 4 Unknown Completed HYPER TEWSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy page ? perform certificate 1 ☐ Yes 2 ☐ No or Attending Physician; 26. Place of Death (Check only one, Be 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this within 24 hours after death.

To the Funeral Director; After thi comoletely filled in by the funeral 27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 500,216 7740324 JANUARY 18, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TERRY JODRIE, MD 7503 SURRATTS ROAD CLIWTON, MARYLAND 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/200

Jacqueline Michell			State	of Maryla					d Menta	al Hygi	ene		200	١.٥	0 (201
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Wedical Examine		Jacquelin 4a. Facility Name (if not instit	e Mi	ichelle street and num	Camp	ретт	4b	. City, Town, or	Location of		allually I		inty of Deat	th		
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Funeral	7	5. Social Security Number	6. Se	x 7	7. Age (In yrs	. last birthday)	-	If Under 1 Yea			Date of Bi	rth(MM/DD/Y	YYY) 9. Bi	irthplace ountry)	e (State o	or Foreign
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r 28a	Director	9101 Branchv	iorr De					2074	4		l	Unite				
		11. Marital Status	TCW	12. Was Dece	edent Ever in	U.S. 13.	Nas	Decedent of His		n? (Specif	y Yes or N	0- 14.1	Race - Ame	erican Ir	ndian, Bla	ick,
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2121 2121 ould be fi ! Mental ! marked ic event,		Colin Jose C	ampo onship (T	ype, Print)		19b. Mai	ling /	Address (Stre	et and Num	ber or Rura	Route Nu	umber, City or	r Town, Sta	ite, Zip	Code)	
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Baltimore, permit. Pages Lan Department of Hea important: If itea injury or other tr	1	4 Donation 5 Othe			M	Marylan	d 1	Nationa	1	1/19	/2008	Laur	e1, M	ld.		
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Examiner	1	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):														
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	Examiner	(Disease or injury that initiatevents resulting in death)	ed C.	Due to (or as a	consequence	e of):								+		
uted nd ransit		events resulting in death / E	d.											_		
(0, e be executed ysician and burial - transit	edical	UNPENDED	E	AMENDED												
760 icate b	§	IF FEMALE: 23b. Was decedent pregnant	in the		outcome of pr								ate of deliventh	ery Day		Year
Sox 6876C	틸	past 12 months?		1 Live b	irth ant at time of	2 f death 5		er (Specify)	Ectopic	pregnancy	/	Mo	ПП	Day		T COI
Box e death of the atter	Physician/M	1 Yes 2 No 9	Unknow		own		Olii	er (op o)					,			
O. I		Part II. Other significant co	nditions	contributing to	death but no	ot resulting in t	he ur	nderlying cause	given in Pa	irt I.		tobacco use				
G, P	ğ o				-							es 2 ✔ N				
ords, P.O. w requires that the as been signed by t	흫											opsy		to comp	oletion of	
Recol	Completed										1 Yes	formed?	death		2	No
of Vital Records, ig Physician: The law requir ther this certificate has been so meral director, page 2 should it	Be C	25. Was case referred to me examiner?							ce of Death				[77]			
Vit	2	1 ✓ Yes 2 No				✓ ER/Outpat			Other 4	Nursing H		Residence		ther:		
ISION OF Attending Ph r death. ector: After t by the funeral	- 1	27. Manner of Death 1 Natural 5	Pending	28a. Date (Month Jan 13.	of Injury Day Year) 2008	28b. Time 1945 hrs		''	ury at Work Yes 2 ✔	. Isi	ubject st	not	JCCurred			
Siol Attend death cetor: by the	(₹		nvestigat	ion		At home farm	stree				Sf. Location	(Street and	Number or	Rural F	Route Nu	mber, City
Division spital or Attendi hours after death. meral Director: /	Certification:		Could not determine	be	28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street an or Town, State) (Specify) Parking Lot 28f. Location (Street an or Town, State) 4850 Mariboro Pike,											
		4 ✓. Homicide 29a. Certifier (Check only 1 Certifying	g Physic	ian: To the bes	st of my know	ledge, death o	ccurr	ed at the time,	date and pla	ace, and du	e to the ca	ause(s) and m	nanner as s	stated.		
To the Howithin 24 h To the Fur	Medical	- 123		er: On the basis and manner s	of examination tated.	on and/or inves	tigati			curred at tr	ie tille, da		te signed (r)
	2	29b. Signature and title of co	entitier	000					nse number .M.E.			- 1	iry 14, 20		Day, redi	,
	ļ	Tate U.	-	roll.	مرير				141			Julia	., ., .,			
CR (10)		30. Name and address of pe Patricia Aronica-P				_{Item 23a)} al Examine	r	111 Penn 9	Street, Ba	altimore,	MD 212	201				
Sta Registr		31. Date filed (Month, 20)	8"	32. Re	egistrar's Sign	native	,									
Kegist	للته					OPICI										

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 08 01 essie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Adventist 8. Date of Birth (Month, Day, Year) 1 □ M 2 🗙 F 578-28-4068 Sept 25. 1925 | South Carolina Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10b. County 10a. State ty⊡Yes 2 □ No Director Maryland Montgomery Gaithersburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20877 407 Russell Ave. G2 United States 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married African 1 ☐ Yes 21 No ģ 3 Widowed 4 Divorced American Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>12 years</u> Beautician Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ George Hamilton Caren Hamilton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Calvin P. Crosson - Husband 407 Russell Ave. G2 Gaithersburg, MD 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 □Removal from State Fort Lincoln Cemetery Jan 24, 2008 Brentwood, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. ure of Fun - L Service Lic inse 4001 Benning Road, NE Washington, DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or deart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. If the cause of cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 1 Yes 2 No 5 Other (specify) 4☐Pregnant at time of death 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopu, performed r 2 No 26. Place of Death (Check only one)

Physician /Medical Examiner

Funeral

Director

28a-f show be notified at

ö death with

iral", or items 23a Examiner must b

event, the Medical

traumatic

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is in any injury or other traum once.

2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or item

3altimore, Maryland 21215-0036

Examiner physician and s the burial-trans Physician/Medical attending p use as sate has been signed by the a page 2 should be detached Be Completed by certificate funeral director. Certification: To After after death filled in by

The law requires that the death certificate be executed

Box 68760,

P.O. I

Division or Vital Records,

Hospital or Attending Physician:

24 hours a e Funeral I

within 24

completely

25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA . Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

65478

29d. Date signed (Month, Day, Year)

01-16-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Moh Ardekani Fanaei, M.D. 9931 Medical Center Dr. Rockville, MD 20850

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year, 32. Registrar's Sig Z008 IAN 2 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. George Coleman State of Maryland / Department of Health and Mental Hygiene 2008 03250 1- For State Certificate of Death Reg. No Registrar 3. Time of Death 2. Date of Death Physician/ 1. Decedent's Name (First, Middle,Last) Month Day January 15, 2008 COLEMAN **GEORGE** 1005 hrs Medical Examiner c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince Georges Hospital Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Country IRGINIA Months Days Hours JULY 25 1945 Director 62 225-62-5831 1 X M 2 Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 No DISTRICT HEIGHTS s 23a or 28a-f show e notified at once 28a-f show PRINCE GEORGE'S hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20747 # 218 2140 BROOKS DRIVE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11 Marital Status or items Armed Forces? ARMY If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 X Married 1 X Yes BLACK Divorced If Yes. Give Year Yes 2 X No specify: Specify: than "natural" ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 l ment of Health and Mental Hygiene. If item 27 is marked other than ' GOVERNMENT Baltimore, MD 21215-0036 MEDIC 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SALLY ANN OGBURN .TOHN T. COLEMAN

19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 2140 BROOKS DRIVE # 218 DISTRICT HEIGHTS, MD 20747 ROSANN COLEMAN/WIFE 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 X Burial 2 Cremation 3 Removal from State CLINTON, MARYLAND RESURRECTION CEMETERY 1/19/2008 Donation 5 Other Specify 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death a. Hemopericardium Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): b. Ruptured Myocardial Infarction Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last requires that the death certificate be executed and Physician/Medical the attending physician ed for use as the burial -UNPENDED AMENDED Box 68760 23d. Date of delivery IF FFMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Live birth Fetal death 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ No 3 Probably 4 ✔ Unknown 1 Yes 2 Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy The law this certificate has performed? death? ✓ Yes 2 1 🗸 2 No Yes 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Be examiner? Other₄ Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 V Yes No 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 1 V Natural Yes 2 Director: d in by the f Pending 24 hours after death. 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be 3 Suicide determined To the Funeral (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number DOME O.C.M.E. January 16, 2008 who completed cause of death (item 23a)

31. Date filed (Month, Day, Year) State Registrar

Theodore M. King, Jr., MD.

32. Registrar's Signature

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

Director

Funerai

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Completed

Be

Physician /Medical Examiner

Funeral Director

f show the Madical Examiner must be notified at ō Items 23a 6 natural 2 should be finand Mental H permit. Pages 1 and 2 should be Department of Health and Mental Important: if Item 27 is marked c any injury or other traumatic ew ones.

within 72 hours after

Maryland 21215-0036

Baltimore,

Physician /Medical **Examiner**

Examiner

Physician/Medical

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Completed

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Certification:

Medical

The taw requires that the death certificate be executed physicien a s the burialass use page certificate or Attending death. after death Director: filled in by

o ے

Records,

of Vital

Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death COLITA January 2008 12:12 A_M DENISE CLARK-BOOZE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3107 Healthcote Road Waldorf Charles | Months | Days | Hours | Min. | S. Date of Birth (Month, Day, Year) | Peb. 18, 1966 | Washington, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Months 1 □ M 2 X F 41 578-88-6658 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 No Maryland Charles Waldorf 10e. Street and Number 10g. Citizen of What Country? 3107 Healthcote Road 20602 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married African 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Unit Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Raymond Thompson Clark Shirlev Ann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donnell Booze (Husband) 3107 Healthcote Road Waldorf, MD 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Harmony Memorial Park 1/25/2008 Landover, MD 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jordan Funeral Service, ANN Glaine 4001 Berning Road, NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (F disease or condition resulting in death) From ovoris Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Ovanu Due to (or as a consequence of): Van IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🕽 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes

24a. Was an autopsy performed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical 1 ☐ Yes 2 ☑ No

27. Manner of Death 5 Pending

6 Could not be determined

28a. Date of Injury (Month, Day Year) investigation

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5 Desidence 6 Other (Specify)

old Banner Aven Temp HIII No

29a. Certifier (Check only one)

1- Natural

2 Accident

3 Suicide

4 - Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Physician

Worrby-An utcheson

State Registrar 31. Date filed (Month, Day, Year) 2008



within 24 hours a To the Funeral (

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Day Clyde Muriel Cofiell P. M 01 14 2008 1:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Center for Hospice Care Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 218-26-4244 1 XM 2 ☐ F 77 Director 05/01/1930 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Me Iral Examiner must be notified at 1 ☐ Yes X No Director Maryland Baltimore Sparks Glencoe 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code United States 21152 16501 Dubbs Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No 1951− If Yes, Give Year or Dates: 1953 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: White Specify. <u>Ş</u> 3 XWidowed 4 ☐ Divorced 1953 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene Important: If them 27 is marked other than " any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Construction Company Vice President 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clifton Cofiell Mary Naylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16506 Dubbs Road Sparks Glencoe, Maryland 21152 Joyce C. Westfall - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 01/17/2008 Timonium, Maryland Dulaney Valley Mem. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Eline Funeral Home 934 South 21. Signature of Funeral Service Licenses Main Street Hampstead, Maryland 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER **Physician** IN ears disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ lungdisease 1 Yes 2 No 3 Probably 4 Uriknown Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s has autopsy performed 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Detather (Specify) Ho 1016 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 2 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Jivision or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Medical WJL AVITEI

State

Registrar

and manner stated

29c. License number 025205 JAnuary 16,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt)

BMC 6781 N. Chile St. Ba Go. Md 21208

31. Date filed (Month, Day,

(Check only one)

32. Registrar's Signature

2008

Gloven & Sparke

		1 - For State Registrar	State of Marylar		tment of F			ene UU	0 03233
Physi	ician	Decedent's Name (First, Middle, Last	")				Date of Death Month		3. Time of Death
	dical	John Russell Co	erame				January	Î3 20Ŭ	8 0400 м
Exam	niner	4a. Facility Name (If not institution, give Carroll Lutheran			-	r Location of Death inster		4c. County of C	rroll
Funera Directo		5. Social Security Number 6. Se 128-07-3996 15 Usual Residence of Decedent	7. Age (In yrs MAM 2□F 93		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day June 23	^Y 914 9.	Birthplace (State or Foreign Country) NY
Maryland I ehow	tor	10a. State 10b. County MD Carre		ity, Town or Loca Finksbu					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
th with the 23e or 28s	Funeral Director	10e. Street and Number 1611 Davinda Dr	ive		10f. Zip Code 21	048	10	g. Citizen of Wha USA	t Country?
ours after dea	à	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates:	If Y	as Decedent of Horses, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto I Specity:	orfy Yes or No- Rican, etc.)		American Indian, White, etc. White
72 h	etec	15. Decedent's Ed	ucation de completed)	16a. Deceder	nt's Usual Occup nd of work done	ation during most of workii	10	6b. Kind of Busin	ass/Industry
ad within glene. er than t. the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	lite. DC	NOT use retired	d) .		nternal	Revenue Serv
Duid be fill Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last) Mario Cerami				18. Mother's Name Angelina	Puleo		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Hyglene. Departmen		19a. Informant's Name/Relationship (T Inez Maguire/daug	hter	19885	_	and Number or Rura eld Road	Finksbu	rg, MD	21048
		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 🖾 Other (Special)		Place of Disposition of Communication Commun	tory or other place	ery 1/17/		Oc. Location - City ikesvill	
permit. Departn Imports eny Inju	- Buce	21. Signature of Funeral Service Licens	0			erariiiHome			
Physicia /Medica Examine	al	23a. Part I Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	dations hat cause the dearecause on elimine. a	th. Do not enter					Approximate Interval Between Onset and Death
icate be executed physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b						
To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours effer death. To the Funerel Director: After this certificate has been signed by the estending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 □E	ctopic pregnancy Other (specify)	1		23d. Date of Month	delivery Day Year
juires that n signed b	<u> </u>	Part If. Other significant conditions co	entributing to death but not re	sulting in the und	erlying cause giv	en in Part I.			te to the cause of death? Probably 4 Dunknown
ne law require hes been si ge 2 should t	ompleted						24a. Was an autopsy perform	24b. Wer prior ed?, deat	e autopsy findings available to completion of cause of h?
icien: Th certificete rector, pag	ပိ						1 ☐ Yes 2	₽No 1□	Yes 2□⊀6
ysicien: The is certificate he director, page	00	25. Was case referred to medical examiner?	Hospital:	7.500	aC DOA Oth	26. Place of Death			
ing Phys After this uneral di	on; To	27. Manney of Death 1 Natural 5 Pending	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur	y at k?	ne 5 Resider 28d. Describe hov	nce 6 Other (Specify)
or Attend offer death Director: in by the f	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h	nome, farm, stree		Yes 2 No	28f. Location (Str. City or Town,	eet and Number of State)	r Rural Route Number,
To the Hospital or Attending P within 24 hours effer death. To the Funeral Director: After toompletely filled in by the funeral	edical Ce	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	/sician: To the best of my kn iner: On the basis of examin	owledge, death o	occurred at the tir stigation, in my o	me, date and place, a pinion, death occurre	and due to the car ed at the time, da	use(s) and manne te and place, and	r as stated. due to the cause(s)
othe ithin : o the	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	29	d. Date signed (A	Ionth, Day, Year)
MIL		> helly	MD			52025		Jan	15 2008

Registrar DHMH 17 Rev 1/2001

State

ORIGINAL

Workmenter

MD 21157

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)
JAN 1 7 2008

JAN 1 7 2008

GINU CHACICO

Division or Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

State Registrar

OTH

29b. Signatur

30. Name and address of persor

Year.

31. Date filed (Month, Day,

death (Item 23a) (Type, Print)

MD

egiatrar's Signature

32. R

2008

29c. License number

29d. Date signed (Month, Day, Year)

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.

Division of Vital Records, P.O. Box 68760,

ician dical		Gladys Soto C	Crespo					2008	5:13.p M		
niner		4a. Facility Name (If not institution, gi	ive street and number)		4b. City, Town, o	or Location of Death		c. County of Deat			
	ı	901 Barnet Lane	e #302		Aberdee			Harfor	rd		
al			Sex 7. Age (In yi	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birt	hplece (State or Foreign		
or		127-20-2030	1□M 2 2 F 74	Yrs.	World's Days	Flours Milit.	1/26/1934		erto Rico		
To Be Completed by Funeral Director	-	Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Lo	antinu.						
5				-					10d. Inside City Limits		
Director		MD Harfo	ora	Aberde					1⊠Yes 2 No		
급		10e. Street and Number			10f. Zip Code			itizen of What Co	untry?		
a	-	901 Barnet Lane	7		2100)1	U	J.S.A.			
Funeral		11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No	U.S. 13.	Was Decedent of H f Yes, specify Cubi	lispanic Origin? (Spec an, Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - Ame Black, White			
b y		3 ☐ Widowed 4 XXvorced	If Yes, Give Year or Dates:		1⊈Yes 2∏No	Specify:		Specify: I	Puerto Rican		
Completed		15. Decedent's E	Education	16a. Deced	dent's Usual Occup	ation	16b.	Kind of Business/	Industry		
lg'	-	(Specify only highest grant Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of workin	g		,		
6	1	12		Socia	al worker			Social S	Services		
Be (17. Father's Name (First, Middle, Last	t)			18. Mother's Name	(First, Middle, Maide	n Sumame)			
2		Unknown			Andrea Torre						
ľ	1	19a. Informant's Name/Relationship ((Type, Print)	19b. Mailin	19b. Mailing Address (Street and Number or Rural Route Number,				Tip Code)		
		John Crespo (So	604	Cole St.	Perrvv	ille, MD	21903				
	12	20a. Method of Disposition		. Place of Dispos		Da		ocation - City or	Town, State		
		1 ☐ Burial 2x☐Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		-	erris & C	· 1 •	/08 Wes	t Cheste	r. PA		
		21. Signature of Funeral Service Lice							21, 121		
		Tarring-Cargo Funeral Home, P.A.									
		Aberdeen, Marvland 21001–3399 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Retween									
in		shock, or heart failure. List only Immediate Cause (Final	A A	rain					Interval Between Onset and Death		
	1.7	disease or condition resulting in death)		6mm.							
		Immediate Cause (Final disease or condition resulting in death) a. Corveracy Orthry Design Grant Death 6 mg. Due to (or as a consequence of)									
-	1 5	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
nlu		cause. Enter Underlying Cause (Disease or injury									
Examiner	t	that initiated events resulting in death) Last	c. Due to (or as a conse	aduence of):							
	Due to (or as a consequence of):										
dic	d										
sician/Medical		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy									
ciar	-	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 2☐Fel	tal death 3 🗌	I death 3 Ectopic pregnancy			23d. Date of delivery Month Day Year			
		1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown						***************************************	- Cul		
ر	Post II. Other significant and idian										
Ď		The later Man I to						e. Did tobacco use contribute to the cause of death?			
etec	-	1/2	1 Comme				1 Yes 2	. □No 3 □ Pro			
n je	1	New Marilla of 1	2-11	24a			24a. Was an 24b. Were autopsy finding				
	-	1 1 1000000 1	as fund en	nen				240. Were aut	opsy findings available		
õ	-	- Jacob A	as fair ei	nea			autopsy performed?	prior to co	opsy findings available ompletion of cause of		
0	2	25. Was case referred to medical	as form er	nen		26. Place of Death	autopsy performed?	prior to co	opsy findings available ompletion of cause of		
o Be	2	examiner?	Hospital: 1 Inpatient 2	☐ ER/Outpatient	3□ DOA Othe	26. Place of Death	autopsy performed? 1 Yes 2 2 No	prior to condeath?	opsy findings available ompletion of cause of		
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Certification; To Be	2	examiner? 1 Yes 2 No 17. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 19. Certifier 10 Certifying Ph	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 1 Y	at ? 28	autopsy performed? 1 Yes 2 D No Check only one 5	prior to code death? 1 Yes 6 Other (Speciary occurred	opsy findings available ompletion of cause of 2 No		
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edical Certification; To Be	2	examiner? 1	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At he building, etc. (Special Special Sp	28b. Time of Injury nome, farm, stre ify) lowledge, death ation and/or invention	28c. Injury Work M 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	at ? 28 e, date and place, an- inion, death occurred	autopsy performed? 1 Yes 2 D No Check only one 5 A Fesidence d. Describe how inju 6. Location (Street ar City or Town, State d due to the cause(s at the time, date and	prior to code death? 1 Yes 6 Other (Speciary occurred) and Number or Run and Number as set of place, and due to the signed (Month,	opsy findings available ompletion of cause of 2 No 2 No fy) al Route Number, stated. o the cause(s)		
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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Clarence Wesley January 7:30 p.M 30 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3251 Ward Kline Road Myersville Frederick 8. Date of Birth (Month, Day, Year July 17, 1 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 90 220-09-7003 Ĩ917 Director Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√E No Director Maryland Frederick Myersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3251 Ward Kline Road 21773 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. and 2 should be filed within 72 hours after o salth and Mental Hygiene. n 27 is marked other than "natural", or iter 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Wood Milling 8 Millwright 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucy Virginia Rice Cline Henry John ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3860 Unit 1-C, Shadywood Drive, Jefferson, MD 21755 permit. Pages 1 and 2
Department of Health a
Important: If Item 27 is
any Injury or other trai Howard E. Cline/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Mt.Zion U.Methodist Feb.4,2008 Myersville, Maryland 5 ☐ Other (Specify) 4 Donation Fune al Service L 21. Signatury 22. Name and Address of Facility 504 Main Street Ricketts Funeral Home Myersville, MD 21773 23a. Part1. Inler the disease, or complications that caused the death. Do not enter the mode of dying, such as circliac or respiratory arrest, shock, or heart failure. List only one cause or eight line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Physician/Medical Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the hirrial IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes ate has been si page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2□ No 1☐ Yes 2☐No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification: To this 27. Manner eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident I or Attend after death Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

Division or Vital Records, Hospital To the

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DHMH 17 Rev 1/2001

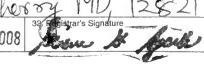
State Registrar

31. Date filed (Month, Day, Year) FEB 06

(Check only

29b. Signature and title of certif

30. Name and address of pe



and manner stated.

son who completed cause of death (Its

(Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 8:58 A Louis A. Day, Jr. January 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) Wash., D.C. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 6,1922 Days 1**∑**M 2□F 577-18-2948 85 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Y□Yes 2□No Grasonville Oueen Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21638 635 Oyster Cove Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: ₩₩ II 14. Race - American Indian. Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify. White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Co. Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Estelle Terrell Louis A. Day, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 635 Oyster Cove Drive Grasonville, MD. 21638 Louise S. Day / spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 01/18/08 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD. 20715 Tou 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 TYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation

The law requires that the death certificate be executed burial-transi Division or Vital Records, P.O. Box 68760, physician the as attending use for ed by the a detached for certificate has t irector, page 2 s or Attending Physician: director, After within 24 hours after death To the Funeral Director: l in by t To the Hospitai

Examiner Physician/Medical Completed by Medical Certification: To Be filled

Physician

/Medical

Examiner

Funeral

Director

rai", or items 23a or 28a-f show Examiner must be notified at

Director

Funeral

þ

Completed

Be (

2

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show

'natural", or

the Medical E

27 Is marked other traumatic event, t

permit. Pages Department of I Important: if its any Injury or o

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

completely

31 Date filed (Month, Day, Year) State Registrar

3□ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of cortifier

30. Name and address of person

32. Registrar's Signatu

who completed cause of death (Item 23a) (Type, Print)

MD

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

JAN 2 2 2008

6 Could not be determined

1 ☐ Yes 2 ☐ No

🗠 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-00814 State of Maryland / Department of Health and Mental Hygiene Charles Edgar Dewhirst Certificate of Death 1- For State Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day January 29, 2008 1448 hrs Charles Edgar Dewhirst Medical Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Prince George's Hospital Center Cheverly 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign Maryland Months Davs Hours Nov. 22, 1960 Director 577–90–3223 XX M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State Yes 2XXXNo is 23a or 28a-f show e notified at once. Forestville Prince George's Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20747 USA 1212 Eastwood Drive 14. Race - American Indian, Black, death with 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 XX Never Married 2 Married Yes 2XX No White 1 Yes 2XX No specify: Specify f Yes, Give Year Divorced Widowed ۾ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) rmit. Pages I and 2 should be filed within 72 I partment of Health and Mental Hygiene. portant: If item 27 is marked other than " or other traumatic event, the Medical Machinist Private Industry MD 21215-0036 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clarence J. Dewhirst Shirlev | Ailes Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 711 Levte Place Oxon Hill. Maryland Shirley Dewhirst / Mother Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place)
Ft. Lincoln Cemetery 1 X Burial 2 Cremation 3 Removal from State 02/02/2008 Brentwood, Maryland Donation 5 Other Specify: 22. Name and Address of Facility George P. Kalas Funeral Home P.A. ure of Funeral Service Licensee 6160 Oxon Hill Road Oxon Hill. Maryland Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line. Death /Medical Coronary artery thromobus Immediate Cause (Final disease amine or condition resulting in death) Due to (or as a consequence of): Atherosclerotic cardiovascular disease Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last requires that the death certificate be executed Physician/Medical X UNPENDED attending physician or use as the burial TYPERe a-b, 27, perME, C876, 2/25/08 TT 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Month Day Year 3 Ectopic pregnancy Live birth Fetal death past 12 months' Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. Yes 2 ✓ No 3 Probably 4 Unknown ģ Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? No 2 ✓ Yes 2 1 Yes certificate 26 Place of Death (Check only one) 25. Was case referred to medical Be Other 4 examiner? Residence 6 Other Hospital: , Inpatient 2 V ER/Outpatient 3 DOA Nursina Home 5 1 V Yes No ۵ 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: Yes 2 No 1 X Natural Pending Director: d in by the f 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be or Town, State) Suicide determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical

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OCME 2006

State

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

January 30, 2008

1000

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Tasha Greenberg MD.

31. Date filed (Month, Day,

and manner stated

WD

Assistant Medical Examiner

egistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 200 \$ ndrew Edwards Jan /Medical County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Nursing tow 920 Columb19 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. S 7. Age (In yrs. last birthday) Social Security Number Date of Birth (Month, Day, **Funeral** Months Days Min. 1**X** M 2□ F 83 240-30-2491 Yrs June 15,1924 North Carolina Director Usual Residence of Decedent death with the Maryland 10d, Inside City Limits 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f show r traumatic event, the Medical Examiner must be notified at 1XYes 2□No Director District of Columbia Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3063 Clinton Street, N. E. 20018 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after in and Mental Hygiene.

is marked other than "natural", or itei 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Be Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Safeway Food Stores Meat Selector 8th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edwards Celia Green Bartemaus ပ 19a. Informant's Name/Relationship (Type. Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Adrienne Celia Edwards 12910 Claxton Drive; Laurel, Maryland 20708 permit. Pages 1 and Department of Health Important: If Item 27 any injury or other ti 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 Removal from State Cedar Hill Cemetery Jan. 26, 2008 Suitland, P.G., Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. val Between et and Death Immediate Cause (Final disease or condition resulting in death) STrok Physician /Medical vascular diseas Due to (or as a consequence of): Examiner Phela Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical use as t attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performe 210 No certificate Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division or Vital Records, Hospital or Attending hours after death. uneral Director: / death. 24 hours a

Medical completely State Registrar

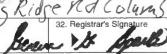
Date filed (Month, Day, Year) JAN 2 3 2008

29b. Signature and title of certifier

(a

29a. Certifier

(Check only one)



and manner stated.

30. Name and a viress of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical (29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	nysician: To the best of my knowniner: On the basis of examination and manner stated.	wledge,	death occurre or investigation	d at the tim n, in my o	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause date a	(s) and manner and place, and du	s stated. se to the cause	⇒(s)
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•	_		30 Name and address of person area	completed cause of death (Hamm	220\ /T-	una Print\		110	× >		000	206	~ 0	
	3		30. Name and address of person who			3 Mn	Lyc	UIN	-	, one	<i>Q</i> .	206	13	
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	Registr	ar	FEB 0 6	2008	A.	15034								

Division or Vital Records, P.O. Box 68760.

Baltimore, Maryland 21215-0036

State Registrar

(Check only one)

29b. Signature and title of certifier

M.D. 11701 Livingston Road, #101 Fort Washington, MD 20744 William T. Tanner, 31. Date filed (Month, Day, Year)

JAN 2 2 2008

30. Na an oddress of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D45361

29d. Date signed (Month, Day, Year)

January 18, 2008

	For State Registrar			Marylan		artmen rtificate			and M		Reg. No.	乙 日日 8	
Physician /Medical	1. Decedent's Pearle	Name (First, Middle, L ena Georg								2. Date of D Month 01 /	Day	2008 Year	3. Time of Death 11:00 a M
Examiner	and the state of t					4b. City, Town, or Location of Death Temple Hills Prince Georges				ith			
Funeral Director	5. Social Secur 246–78–1.		Sex 1□M 2□F	7. Age (In <i>yrs.</i> 58	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of B (Month, L 09/05/1	irth Day, Year) 1949	9. Bir Co Nort	nthplace (State or Foreign ountry) h Carolina
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or 28a-f	MD 10e. Street and			'l'en	ple Hil	LS 10f. Zip	Code				10g. Citi	izen of What C	
seth wi	4904 Bres	ntley Road	12. Was Dece	dent Ever in II	S 13	1)748 lent of His	enanic Ori	nin? (Sne	cify Yes or N	_	KA 14. Race - Am	erican Indien
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after deeth with the Maryland 1 and 2 should be filed within 72 hours after deeth with the Maryland Item 27 is marked other than "natural", or Itams 23s or 28s-f show other treumatic event, the Medical Examiner must be multilised. To Be Completed by Funeral Director	1 Never	Married 2⊡ Married red 4√⊋Divorced	Armed For	ces? 2 🙀 No e		If Yes, spec	ofy Cubar	Specify:	i, Puerto i	Rican, etc.)		Black, Whi	
21215-0036 od within 72 hours alt general ser than "natural", or it, the Medical Exerni Completed by F		15. Decedent's Specify only highest (Secondary (0-12)	Education grade completed) College (1	-4or 5+)	(Give	dent's Usua kind of wor DO NOT us	rk done d se retired)	uring mosi	t of workir	ng	16b. Ki	ind of Business	s/industry
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The law The law page 2 sl										24a. Wa au pe 1 🗆 Yes	topsy rformed?	prior to death?	
n of n of ng Phys after this interal din	25. Was case examiner? 1 Yes 27. Manner of 1 Natura 2 Accide	No Death al 5 □ Pending	28a. Date of		ER/Outpatie 28b. Time o Injury		8c. Injury Work	9C 4 □ Nu	rsing Hor	me 5 A Re 28d. Describ	sidence	6 □Other (Sp.	ecify)
Division C To the Hospitel or Attending P within 24 hours after death. To the Funeral Director: Alter t completely filled in by the funeral Medical Certification;	3 ☐ Suicio 4 ☐ Home		289. Place	of Injury - At h	ome, farm, st	e, farm, street, factory, office 28f. Location (Street and Number or Rural Route Num City or Town, State)			Rural Route Number,				
DIVI To the Hospitel or At within 24 hours after of completely filled in by Medical Certifi	29a Certifier (Check on one)	1 Cartitying 2 Medical Ex	Physician: To the aminer: On the ba and mann	asis of examina	owlodge, deat ation and/or in	h occumed ivestigation	at the two	e, date an pinion, dea	id plane :	and due to the	e, date an) and make of a d place, and du	ue to the cause(s)
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e 0	30. Name and	1	completed caus	e of death (Iter	m o a) IT ce.		y 00	10	CLIT) . i . c	Com	There	MD 2071
State Registrar	31. Date filed JAN	(Month, Day, Xear)	Slower States	egistrar's Sign	both	, car	ech	200	(Tr J	11:00	Cire	C. I. Sect	TO LUIC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Garland Bennett 1627 M 2008 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arundel Medical Center Anne Arundel thnapolic thne If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Year) Country) Mary land 150M 2 F NIA Director 0111712008 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or than "natural", or Items 23s or 28s-f show Anne Arundel 1 Yes 2 00 Md. Odenton by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2389 21113 Sandy United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Itsm 27 is marked other than "natural", or Item 1 Never Married 2 Married 1 ☐ Yes 2 2 ♣ O Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (9-12) College (1-4or 5+) NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maria Garland Calabretta Eugene ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Odenson, Md 21113 Michael Garland / Father 2389 Sandy Walkway 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 1/23/2008 Baltimore, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Semi Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, Md 21401 12 Ridgely Ave. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Holoprosencephali, minutes Due to (or as a consequence of) Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner ettending physicien and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? δ cete hes been sig page 2 should b

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

Completed Be မှ Certification:

or Attending Physician: The law requires that the death certificate be executed

this certificete After this certification funeral director.

Director: A

Medical

State Registrar

within 24 hours after To the Funaral Dira

Division of Vital Records, P.O. Box 68760,

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part

1 🗆 Yes	2 30 10	3 Probably	4 []Unkno

		24a. Was an autopsy performe
Was case referred to medical	26. Place of Death (Che	ack only one)

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
☐ Yes 2☐ 40	1 ☐ Yes 2 ☐ No

1 163 20	0
27. Manner of Death	
1 Natural	5 Pending
2 Accident	investigation
3 Suicide	6 Could not be

 1 patient 2	ER/Outpatient
28a. Date of Injury (Month, Day Year)	28b. Time of Injury

Other:	4 🗌 Nursing H	ome	5 🗍 Resi	dence	6 Other (Specify)
Injury at Work?	2 □ No				y occurred

	28d.	Describe	how	injury	occurred	
No						

determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Locati City o
	1	1

3□ DOA

М

28f.	Loca City	ition or To	(Street wn, St	and ate)	Numbei	ror	Rural	Route	Numb	er
 	al a.			(-) -						

(Check only one)	29a.	Certifier
		(Check only one)

4 Homicide

1 sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the caused Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date a and manner stated.	(s) and manner as stated. Ind place, and due to the cause(s)

	DO	0	6	58	76
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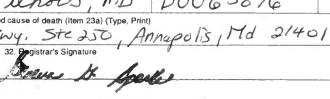
29d. D	ate sign	ned (M	onth, D	ey, Year)
		/	1.	_
,	\wedge \prime \prime	17	102	Ų

		_
30. Name and	ddress of person who completed cause of death (Item 23a) (Type,	F

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

JAN 2 2 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Cassie Pauline Grace 29, 2008 2131 January, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Havre de Grace Harford Memorial Hospital Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Julie 2ay, 1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2/2 F 87 Yrs. 225-01-2045 Director North Carolina Usual Residence of Decedent with the Maryland Show 10b. County 10c. City. Town or Location 10d. Inside City Limits rthan "natural", or items 23a or 28a-f shore the Medical Examiner must be notified at 1 □ Yes 2KXNo Director Havre de Grace Harford 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 703 Tydings Road 21078 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 TYPes 2 No If Yes, Give Year or Dates: WW∏ 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3€Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker In home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ages 1 and 2 should be fill nt of Health and Mental H it if item 27 is marked oth Dr. Toliver Thacker Anna Lee Harris 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis J. Smith (Daughter) 836 Flintlock Dr. Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department Important: If any injury or Harford Mem. Gdns. 2/4/08 4 ☐ Donation 5 ☐ Other (Specify) Aberdeen, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or compileations that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute **Physician** myolardia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ ¥6 Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by DrD 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 ☐ Yes 2 ☐ No 1 Yes 2 No Vital To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 DER/Outpatient 3 □ DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injuty 5 Pending death. 1 Tes 2 No investigation 2 Accident 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C pelli 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (Whi an 1)32609 30108 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Milhau no 1106 Revalution avred : Grace Moder 78 Kennydin 32. Regittrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 6 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Mary A. Hamilton 1730 Jan 14, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Community Hospital Cheverly, MD Prince Georges If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days Months 1 □ M 2 1 F 579-16-9065 104 Jan 10, 1904 Washington, Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show must be notified at X⊓Yes 2 No Director N/A N/A Washington, 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 21 any injury or other traumatic event, the Medical Example 0000. 2104 Suitland Terrace, SE, #101 20020 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify Completed by Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Domestic Worker Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Hamilton Margaret Hall ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doretha Holley (Daughter) 2104 Suitland Terrace, SE, #101, Washington, DC 2002020b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State Mt. Olivet Cemetery Jan 24, 2008 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Pope Funeral Homes, P.A. 5538 Marlboro Pike 21. Signature of Funeral Service bicenses Linnows 20747 Forestville, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Fatal Cardiac Arrhythmia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tra resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🙀 No Division or Vital Records, P.O. 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No autopsy performe 2**X** No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 🔀 Inpatient 28a. Date of Injury 28b Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 ☐ Homicide To the Hospital within 24 hours at To the Funeral L 29a. Certifier CC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely and manner stated.

of person who completed cause of death (Item 23a) (Type, Print) Little, M.D., 3001 Hospital Drive, Cheverly, MD

31. Date filed (Month, Day, Year)

29b. Signature and title

JAN 2 2 2008



State

Registrar

29c. License number

D58957

29d. Date signed (Month, Day, Year)

January

20785

14, 2008

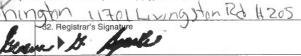
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Physician WESLEY CLYDE HOLDER 9:20 01 15 08 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CLINTON If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 02–27–1957 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Trinidad 1₩ M 2□ F 50 Director 053-54-6260 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f sho dical Examiner must be notifiled at 1***** wes 2 □ No Director Maryland | Prince George's Fort Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20744 2113 Trafalgar Drive Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 KHYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💆 No Baltimore, Maryland 21215-0036 Specify: B1ack 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical College (1-4or 5+) Elementary/Secondary (0-12) Private Industry 12th 5+ Computer Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lurlyne Boland Vernon R. Holder other traumatic ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ft. Wash., MD 20744 2113 Trafalgar Dr. Jeri L. Holder/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 1 Burial 2 □ Cremation 3 □ Removal from State 01-25-2008 Cheltenham, Maryland Maryland Vet. Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Mary Hedgman MO1374 Suitland, MD 20746 Cedar Hill FH 4111 PA Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition months **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No ed by the a Division or Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 212 No certificate 1□ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 TYes ပ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide hours after Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

CR

State Registrar JAN 2 2 2008

30. Name and address of person wh



pleted cause of death (Item 23a) (Type, Print)

F. Washington MD. 20744

			nogiotiai			of Maryl f per	me,g877	artment of I	lealth a	and Mental F	- Trog. Tro.	800	03267
Н	Physici		1. Decedent's Nar	ne (<i>First, Middle</i> IVIN		DGE				2. Date of Month	Day	2008	3. Time of Death
	/Medic Examin				n, give street and no	ımber)		4b. City, Town,	or Location o	of Death	4c. Co	unty of Death	2000 (5
×.	Funeral		3207 ALY 5. Social Security 128–52–6	Number	6. Sex 1 X 0 M 2 ☐ F	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under	24 Hrs. 8. Date of (Month,	Birth Day, Year)	9. Birthp	lace (State or Foreign
k	Director		Usual Residence		M 201	40	Yrs.			JULY	28 196	l NEW	YORK
	farylan show ed at	ō	10a. State	10b. County	E GEORGE 1		BOWIE	ocation				1	0d. Inside City Limits 1X Yes 2 □ No
with the Na or 28a-f		Funeral Director	10e. Street and N	1				10f. Zip Code 20721				of What Coun	ntry?
5-0036 72 hours after death with the Maryland natural; or items 23a or 28a-f show dical Examiner must be notified at	þ		rried 2 ▼ Marr 4 □ Divorced	12. Was De Armed F 1 ☐ Yes If Yes, G Year or I	orces? 2 X No ive		Was Decedent of If Yes, specify Cut	oan, Mexicar	gin? (Specify Yes or i, Puerto Rican, etc.)		Race - Americ Black, White, pecify:		
21215-0036	within 72 h iene. than "natu he Medicai		(Spe		st grade completed College	(1-4or 5+)	16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	during mos ed)			of Business/Ind	•
land 2	land 2	To Be Completed	17. Father's Name			+		MURIGAGE	18. Mothe	er's Name <i>(First, Mid</i> IE MAE AK	dle. Maiden Su	rname)	
Baltimore, Maryland 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	-	19a. Informant's I					,		er or Rural Route Nu			,	
	Pages 1 annent of Heant of Item				3 □Removal fron	State		osition (Name of matory or other pla HEAVEN CE	' i	Date 1/19/2008		ion - City or To	
Balt	permit. Departr Importa any Inju		21. Signature of F	uneral Service	Incensee Mad	euc	1.			yJ.B. JENI ROAD LANDO			
	Physician /Medical Examiner	Examiner	23a. Part1. Enter shock, or he Immediate Cause disease or condition resulting in death Sequentially list of if any, leading to it any, leading to that initiated even resulting in death;		Approximate Interval Between Onset and Death								
, P.O. Box 68760,	t the death certiff by the attending ached for use as	Physician/Medical	IF FEMALE: 23b. Was decede in the past 1 1 ☐ Yes 2 9 ☐ Unknow	2 months? □ No n		birth 2 gnant at time nown	Fetal death 3[of death 5[□Ectopic pregnan. □ Other (specify) _		. 23e. [-	I. Date of delive	ery Day Year he cause of death?
Vital Records,	w requires that been signed be should be det	leted by								1	Yes 2		pably 4 Unknown
tal Re	The la ate has page 2	e Completed	25. Was case refe	erred to medica					26 Place	a p 1 Ye of Death (Check or	erformed?	prior to co death?	impletion of cause of 2□ No
Division or Vi	di is	To B	examiner? 1 Yes 2[27. Manner of De: 1 Natural 2 Accident] No	Hospital: 1 28a. Date (Mo	of Injury nth, Day Ye	. Found	of 28c. Inju	her: 4 🗆 Nu	rrsing Home 521		ccurred	_
Divis	i di it o	Certification:	3 Suicide 4 ☐ Homicide	6 ☐ Could determ	inod Zoe. Plac		At home, farm, st	reet, factory, office		28f. Location City of Bowie		207 Al	ysheba Ct.
	ne Hospital n 24 hours a ne Funeral bletely filled	Medical	29a. Certifier (Check only one)		Examiner: On the					nd place, and due to ath occurred at the ti			
	To the To the Complex	Ň	29b. Signature an	d title of certifie	10	1	2	29c. Licen	se number	2.7	29d. Date s	signed (Month,	Day, Year)
0	(15)		30. Name and ad	dress of person	who completed car				155 9	+1	o O	of - 10	1
	Sta Registi		31. Date filed (Mo	onth, Day, Year) 2 2008	Lyster 32.	Registrar's		ital s		7	J.	any	ad

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Clarence Russell Haines **Physician** 18, 2008 10:00 a^M January /Medical 4b. City, Town, or Location of Death Westminster 4c. County of Death Carroll 4a. Facility Name (If not institution, give street and number) Examiner 215 Sullivan Road 8. Date of Birth (Month, Day, Year) Nov 18, 1929 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**™** M 2□ F Months Days Maryland Hours 78 219-66-3421 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show of al Examiner must be notified at Westminster Carroll 1 ☐ Yes 2 XNo Maryland Director 10g. Citizen of What Country? USA 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 21157 215 Sullivan Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed It of Health and Mental Hyglene.
If Item 27 is marked other than "natur or other traumatic event, the Mental 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item Z7 is marked oth any injury or other traumatic event once. Hilda Marie Six Thomas Russell Haines 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
24 N. Court Street, Westminster, MD 21157 19a. Informant's Name/Relationship (Type. Print) Jeffrey D. Scott, Attorney 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Keymar, MD 1/22/2008 Keysville Union Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MPJast **Physician** 0 al /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine the attending physician and hed for use as the bunal-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1∏ Yes 2 D No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 5 Na Residence 6 □Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Matural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) WJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

DHMH 17 Rev 1/2001

Registrar

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31. Date filed (Month, Day, Year)

32. Regiona's Signature

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	o	g Phys er this eral di	n:T	27. Manner of Dea	ath	-	28a. Date (Mon			28b. Time	of	28c. Inju Wo			28d. Describe				.,,		
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	_			30. Name and ad	dress of person	n who com	npleted cau	se of de	ath (Iten	n 23a) (Typ	e, Print)		eta.	Sok	al mai	>	•				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Month **Physician** 29, Jan. 10:35a M Hershberger David Bruce /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS--Memorial Campus Cumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 30, 1945 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Hours Days 1 M 2 □ F ΜD 213-**44**-1970 Director 62 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at WV Mineral Ridgeley 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with Rt. 1 Box 152 26753 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ☐ No 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 □ **X**o Baltimore, Maryland 21215-0036 Specify Specify: à 3 ☐ Widowed 4 ☐ Divorced white ear or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 owner/operator **H&S** Automotive permit. Pages 1 and 2 should be filed Department of Health and Mental Hygii Important: If Item 27 Is marked other any Injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Peggy McKenzie Hershberger Bruce Hershberger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 1 Box 152 WV 26753 Teresa Hershberger wife Ridgeley 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 1/30/2008 MD Cresaptown 4 Donation 5 Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service 108 Virginia Avenue: Cumberland, MD 21502 First. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Imm diate Cause (Final disease or condition resulting in death) Physician Arteriosclerotic Heart Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Gastrointestinal Bleed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Yes 2□ No 1 Inpatient မ After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.

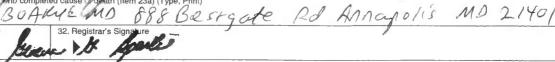
To the Funeral Director: After 5 ☐ Pending investigation **Y** ✓ Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rµral Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier 1 🗌 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type_Print) THIRD ST. D 124 W. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar FEB 0 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1^{Day}, 2008 Physician Month 2:00am м Barbara Turner Jones January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12804 Hadley Lane Bowie Prince George's If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F 224-38-2881 76 Director Sept. 12,1931 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County show 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exa<u>miner must be notified at</u> MD Prince George's Director Bowie 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12804 Hadley Lane 20716 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: White ≥ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Legal Secretary Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Henry Turner ၉ Helene Murray and I 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is other tra Frederick S. Jones / spouse 20716 12804 Hadley Lane Bowie, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If itel
any injury or ott 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Forest Lawn Cemetery 01/22/2008 Richmond, VA. 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licenses 6512 NW Crain Hwy , Bowie MD 20715 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician RHEUMATOID LUNG 42as disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a some quones of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 DEctopic pregnancy 4□Pregnant at time of death 9□Unknown Month Dav Year 5 ☐ Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð CHRONIC OBSTRUCTIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed STOGLENS 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy performed? Yes 2 No RHEUMATUID certificate 1☐ Yes Division or Vital Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death Check onl one Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 5 Residence 6 □Other (Specify) After this funeral dir 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation Virtual St hours after use ...

To the Funeral Director: After a constant of the funeral of the 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 5 30. Name and address of person no completed cause of ath (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)



permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

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than be M	ᇍ	Elementary/Secondary (0-12)		College (1	-4or 5+)		ice Presid	•			of	Cont	rol	Data	
other ent, t		17. Father's Name (First, Middl	e, Last)				100 120010		other's Name	(First, Middle	, Maiden	Surname			
ked o	To Be	17. Father's Name (First, Middle, Last) Albertas B. Johnson 18. Mother's Name (First, Middle, Maiden Surname) Roxie Hill													
s ma Emai		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)												Code)	
n 27 i		Janet Jones/wi	.fe				636 Coon C	Tub	Road	westmi	nste	er, M	D 2	21157	
r iter		20a. Method of Disposition 1 □ Burial 2 □ Cremation	a 3∏Ren	noval from	Ctoto C	emetery, d	sposition (Name of crematory or other pla		1	ate		ocation - C	•		
tant: jury		4 □ Donation 5 □ Other	(Specify)		Lak		w Memorial		i			esvil		MD	
Department of reads and welfared hyperical property and property of them 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee	1			Pritts Fun 412 Washin							21157	
\$ # # _8		23a. Part1 Enter the disease, sho 3, or heart failure. Li	or con plica st only one	tion at c cause on e	aused the death ach line.							100		Approximate Interval Betw Onset and D	veen
sician ledical		Immediate Cause (Final disease or condition resulting in death)	a.		_	strok	ies							weeks	
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George C	e.	Sequentially list conditions, if any, leading to immediate cause Father Uniteditions. Due to (or as a consequence of):											year.	<u> </u>	
ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	5												
an an irial-tr		resulting in death) Last Due to (or as a consequence of):													
physician and s the burial-transit	dical		d												
ling p	0 1	IF FEMALE:													
attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months?									23d. Date of delivery Month Day Year				ear
the s	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4⊟Pregn 9⊟Unkno	ant at time of down	eatn	5 ☐ Other (specify) _	Month Day real							
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After t		27. Manner of Death 1 ☑ Natural 5 ☐ Pend		28a. Date ((Mont	of Injury th, Day Year)	28b. Time Injur	y Wo			8d. Describe	how inju	ry occurre	d		
tor: /	cati	2 ☐ Accident inves	tigation	00 - Di	- f 1 - 1 A A h-			Yes 2	1						
Direc in by	Certification:		mined		ng, etc. (Specify		street, factory, office		2	City or To			r or Hura	al Route Numb	ber,
neral filled	Č E	29a. Certifier 1 Certify	ing Physic	ian: To the	best of my kno	wledge, de	eath occurred at the t	me, date	and place, a	and due to the	cause(s	and man	ner as s	stated.	
To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only 2 Medic	al Examine	r: Ormthe ba	asis of examina ner stated.	tion and/o	r investigation, in my	opinion,	death occurre	ed at the time,	, date an	d place, a	nd due to	o the cause(s))
	Σ	29b. Signature and title of certif	LA	In		29c. Licens				29d. Date signed (Month, Day, Year)					
2		- Duein	M63927 1/14						200	8					
10		30. Name and address of person			. 1				~1	~ d			1 5		- 1
Sta	to	31. Date filed (Month, Day, Yea		32. R	egistrar's Signa	ture	225.6	rcev	re St.	, Balt	mo	re, 1	10	412	01
Registr	_				Glasia.		1								

DHMH 17 Rev 1/2001

amended piece 1/1-28-08/wicehd/man elible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 9,2008 2:10 AM nsor Ine /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rehab + Nursing Ctr. Ulicomico lisbury lisburg If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1934 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yes last birthday) **Funeral** 1□M 2ØF Days Months -30-9305 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No **Funeral Director** anna 0Merse Incess 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or 'must be n 21853 ural", or items 2 Il Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Completed by 3₽Widowed 4 Divorced "natural" Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry or other traumatic event, the Medical tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Worker 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Health and Mental | em 27 is marked of ames ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claughter 19a. Informant's Name/Relationship (Type. Print) Meadow 3700 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 917. W Isabella Street 21. Signature of Funeral Service Licensee Bennie 10816 OM Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op each line. Immediate Cause (Final **Physician** teck 001disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events neces Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transi resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical Sas 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy been signed by the atte should be detached for in the past 12 months? 1☐ Yes 2☐ No Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ 1No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s has autopsy perform 2 □ No 1□ Yes Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1√0 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Inpatient After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending Injury 1 ⊡Natural 5 Pending 1 ☐ Yes 2 □ No investigation after death. 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Hospital 29a. Certifier (Check only one) 1 Gerifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated To the 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 2(Kobin egistrar's Signature 2008 Registrar

08-00863

Eranna Michelle Jenkins

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 03274

			- For State		Certii	ficate of	Death		Reg. N	No		
	Physicia		tegistrar 1. Decedent's Nan	ne (First, Middle,Last)				2	. Date of Death Month Da	v Year		me of Death
F42.	Priysicia • Examir		Eranna		le Jenkins	January 31, 2	2008		905 hrs			
	LAGITIT			(if not institution, give s		4	b. City, Town, or Loc	ation of Death		4c. County o		
				Maryland Hospital		1	Clinton			Prince G	•	
					7. Age (In yrs. las	hirthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birth (N	MM/DD/YYYY	9. Birthplac	ce (State or
	Funerai		Social Security				Months Days	Hours Min.	7 2.7	1075	Foreign Country)	VA
	Director		229-17	-0633 1 _□ N	/ 2 XF	33 Yrs.			Jan.27	, 1975		V -3
		ı	Usual Residence	of Decedent							10d	. Inside City Limits
	any		10a. State	10b. County	10c. City, I	own or Locati	ion				1	X Yes 2 No
	ь ў ў		Md.	PG		Templ	e Hills					
	a-f s	윉	10e. Street and N				10f. Zip Code		109.	Citizen of Wh	nat Country?	i i
7	death with the Maryland or items 23a or 28a-f show any must be notified at once.	Director	1202 2	2nd Place	2		2074	18	1	United	d Sta	tes
71	th th				12. Was Decedent Ever in U.S	13. Wa	s Decedent of Hispar	nic Origin? (Spe	ecify Yes or No-	14. Race	- American I	Indian, Black,
0	th wi	er	11. Marital Status 1 X Never Mai		Armed Forces?	If Y	es, specify Cuban, N	Mexican, Puerto I	Rican, etc.)	VVnite	e, etc.	
	or it	Funeral		1	1 Yes 2 X No	1	Yes 2 X No s	specify:		Specify:	Bla	ck
	ed within 72 hours after death with the Maryland tygiene. other than "natural", or items 23a or 28a-f she the M. dieal Examiner must be notified at once	þ	3 Widowed		or Dates: y highest grade completed)	16a Deceder	nt's Usual Occupation	n (Give kind of w		6b. Kind of Bu	usiness/Indus	stry
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03	within iene. er th M. d	m	12				18	Mother's Name	(First, Middle, Ma			
215-0036				e (First, Middle, Last)			1	Gloria				
21	be fi	Be	Unk .	Paul E. Thom		10b Mailir	ng Address (Street a	and Number or F	Rural Route Numb	er, City or Tov	wn, State, Zip	Code)
21	should be filed within and Mental Hygiene. 7 is marked other that cent, the Med	ြို	l	Name/Relationship (Ty			22nd P					
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	Pages 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. Iant: If Item 27 is marked other than "or other traumatic event, the Medical	- 14	20a. Method of I	Disposition	Removal from State	rematory or 0	other place)	1				
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2	permit. Pages 1 and 2 s Department of Health a: Important: If Item 27 injury or other traum	10	1/1000	ana Ho	A) O a	30	1910 Silv	ver Hi	II. Rd.	Suit	land,	Ma . Z / / 40
		-	23a Part I Ente	r the disease, or compl	lication; that caused the death.	Do not enter	the mode of dying, s	such as cardiac o	or respiratory arres	st, shock, or h	eart	Approximate Interval Between Onset and
F*: L	hysicían ledícal		fellure. List	only one cause on ea	ch inte.							Death
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			or condition les	ulting in death)	Due to (or as a consequence o	1).					- 4	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 Day Month **Physician** 12:30PM JAN 19 YUN KIM HO /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY RANDOLPH HILL NURSING HOME SILVER SPRING | Honder 1 Year | Honder 24 Hrs. | 8. Date of Birth (Month, Day, Yeith Sept. 21 | Sept. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Year) 1 M 2 4 S KOREA 86 1921 Director 217 06 1292 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 XYes 2 □ No MONTGOMERY SILVER SPRING Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 S KOREA 4011 RANDOLPH Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 2 X No 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XIo Specify. Specify: ASIAN þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE HOUSEWIFE 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be PARK KYUNG YUN SAM DO LEE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $100 \quad \text{NEEDLE PINE LN, ANNAPOLIS MD 21401}$ 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra KIM /SON HYO 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State 1/22/08 TIMONIUM DULANEY VALLEY 21. Signature of Funeral S 22. Name and Address of Facility CHARLES HINDS FUNERAL Licensée 12303 KAYAK DRIVE UPPER MARLBORO MD 20772 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Physician/Medical as attending IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by DISEASE STAGE LIVER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Xinknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2: autopsy death? 1 ☐ Yes 2 ☐ No perforn certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 2 funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b, Time of 28d. Describe how injury occurred After 1 Certification: To the Hospital or Attending within 24 hours after death. 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director; A 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Records,

Division or Vital

State **JAN 23** Registrar

1517 HUGO CIRCLE SILVER SPRING MD ALLAN R SEGAL MD, 32. Registrar's Signature 31. Date filed (Month, Day, Year) 2008

30. Name and address of person who completed cycle of death (Item 23a) (Type, Print)



D52261

1/21/08

20906

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** John F. Kirrer 12:12 P ^M 20, January 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Westminster Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 87 135-16-6991 3, 1920 Pennsylvania Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. 'Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 No Director Maryland Carroll Hampstead 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 1211 North Main Street, Unit 118 21074 United States Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1010 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 18 Yes 2 No 1940− If Yes, Give Year or Dates: 1945 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: white þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Item 27 is marked other than "natu other traumatic event, the Medical Baltimore City Fire Elementary/Secondary (0-12) College (1-4or 5+) firefighter Department 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stephen Kirrer Elizabeth Mumper ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If Item 27 is 1 Carol L. Stitz - daughter 3830 Normandy Drive, 3-C Hampstead, Maryland 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 23, permit. Pages
Department of
Important: If it
any Injury or c Jan. 23 2008 3 ☐ Removal from State Finksburg, Maryland Evergreen Mem. Gdns. 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Eline Funeral Home 934 South Main Street M01490 Hampstead, Maryland 21074 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to or as an insequence of): disease or condition resulting in death) /Medical **Examiner** month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Liberase or links y that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner the burial-trar and Due to (or as a consequence of): the attending physician for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Mo 24a. Was an has page certificate 2 No 1□ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Sther (Specify) 1 ☐ Yes 2 ☐ 146 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hispili Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No r death. investigation 2 Accident 24 hours after death Property Properties the 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide

law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. Hospital or Attending Physician:

Baltimore, Maryland 21215-0036

To the I within 24 To the I Registrar

31. Date filed (Month, Day, Year) State JAN 22

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

MOIN

29c. License number

29d. Date signed (Month, Day, Year)

ame and address of person who completed cause of death (Item 23a) (Type, Print)

NOSTHILDTER MD215 5 South 161

1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

32#Registrar's Signature 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 🛭 🗎 🖯 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 712 M /Medical Vanvary 2003 acility Name If not institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death 121 . Social Security Number 7. Age (In vrs. last birthday) **Funeral** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 1 M 2 □ F 220-58-1039 55 Director 03/11/1952 West Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event than "natural", or items 23a or 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside Cify Limits Director MD Allegany LaVale 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1248 Braddock Road 21502 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Be Completed by Specify 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Deputy Sheriff County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lindberg Hall Knotts Mary Louise Cathel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 1248 Braddock Road, LaVale, Maryland Claudia M. Knotts / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mary's Cemetery | 02/01/2008 4 Donation 5 Dother (Specify) Cumberland, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** days /Medical Due to (or as a consequence of) Examiner dias Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (of as a consequence of The law requires that the death certificate be executed 0 and Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) the 9□Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy this certificate 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No P 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation after death Director: 2 Accident 1 Yes 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print) Bultimore North 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 18 Day **Physician** 2008 Charles Ε. Lucas Jan. 4:10 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Morningside House of Friendship Laurel Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 6 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 ☐ F 411-12-3401 90 Aug. 1917 Arkansas Director Usual Residence of Decedent death with the Maryland 10a. State 10c. Cify, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If them 27 is answed other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes X☐ No Director Anne Arundel MDGambrills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Thistle Court 1747 21054 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No Ď Specify Specify: 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Section Chief U.S. Govt. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles C. Lucas Irene Hall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Golda Robinson / daughter 1747 Thistle Ct. Gambrills, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jan. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 MD Veterans Cemetery Crownsville, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD. 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
URUW Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the attending physician and does be detached for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes nis certificate has been si I director, page 2 should i Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence Cother (Spiking ို 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title/of cer 29d. Date signed (Month, Day, Year) willen on with completed cause of death (Item 23a) (Type, Print) ANNAPOUS M DEFENSE MEHWAY

State Registrar

Physicia		I- For State Registrar 1. Decedent's Name (First, Middle,Last)	[2 D:	Reg. No	20(3-Time of Death
dical Exami		DANIEL ERNESTO LOPEZ	M	onth Day nuary 12, 20	Year	1609 hrs
		4a. Facility Name (if not institution, give street and number) Maryland General Hospital Baltimore			c. County of Deat	h
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Months Days	Lieuwe Min	Date of Birth (MM	961 961 Co	
/ any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
daryland 28a-f show any 1 at once.	ţċ	AD BALTIMORE 10e. Street and Number 10f. Zip Code		10a C	itizen of What Cou	1 X Yes 2 No
with the Maryland ns 23a or 28a-f sho be notified at once.	Director	3401 E. BALTIMORE 21224			SALVADO	
death with or items 2.	Funeral	1 Yes 2 X No	, Mexican, Puerto Ricar	n, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland b and Mental Hygiene. 27 is marked other than "naturnl", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once	eted by	3 Widowed 4 Divorced If Yes, Give Year 1 X Yes 2 No 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	ion (Give kind of work d		Specify: WH	
5-0036 led within 72 Hygiene. other than '	Comple	6th Labored				tion, Co.
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medien	Be Co	17. Father's Name (First, Middle, Last) LAZARO LOPEZ	18.Mother's Name (Firs TRANSITO			S
ID 21 should and Mer 27 is man	٩	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street 31anca Estela Lozano (sister) 2000 Leonard I			•	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medici		20a. Method of Disposition 1 X Burial 2 Cremation 3 X Removal from State 20b. Place of Disposition (Name of cem crematory or other place) Las Colinas Cemete	netery, Dat	e 200	c. Location - City o	r Town, State
Balting permit. Pa Department Important injury or	A	4 Donation 5 Other Specify: 21. Sun ture of Funer certification (22. Name and Address)	of Facility Santa	Cruz F	unerales	Latinos, I
Physician	4	23a. Part I. Enter the "sease, or complications that caused the death. Do not enter the mode of dying, sfailure. List only one cause on each line.				D.C. 20011 Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):				Death
j	Jer	Sequentially list conditions, if any, leading to immediate b Due to (or as a consequence of):	·			
cuted and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):				
60, ate be execut hysician and e burial - tra	Medical	UNPENDED AMENDED				
Box 68760 death certificate the attending physical for use as the bu	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Pregnant at time of death 4 Pregnant at time of death 5 Other (Specify)	Ectopic pregnancy		23d. Date of delive Month	ry Day Year
the d		Part II. Other significant conditions contributing to death but not resulting in the underlying cause gi	iven in Part I.			the cause of death?
P.C es that igned to be deta	9			1 163 2		
e law requires that e has been signed to 2 should be detailed.				24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
Records The law requi	e Completed		of Death (Check only of	24a. Was an autopsy performed Yes 2	prior to	utopsy findings available completion of cause of
f Vital Records, P.C Physician: The law requires that rr this certificate has been signed to ral director, page 2 should be detail	ro Be Completed	examiner? 1 Very 2 No Hospital: 1 Inpatient 2 Very ER/Outpatient 3 DOA	of Death (Check only of Other A Nursing Hor	24a. Was an autopsy performed Y yes 2 one)	prior to death? No 1 1 1	utopsy findings available completion of cause of Ves 2 No
of Vital ling Physician: After this certif funeral director,	To Be Completed	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 VER/Outpatient 3 DOA Continue of Injury 1 Natural 5 Pending Panding Pospital: 1 Inpatient 2 VER/Outpatient 3 DOA Continue of Injury (Month, Day, Year) 28b. Time of Injury 1 Ves 2 No 1 Ves 2 No Continue of Injury 1 Ves 2 No Co	of Death (Check only of Other A Nursing Hor	24a. Was an autopsy performed Yes 2	prior to death? No 1 1 1	utopsy findings available completion of cause of Ves 2 No
n of Vital ling Physician: After this certif	To Be Completed	examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Company	of Death (Check only of Other, Nursing Holy at Work? 28d. Yes 2 No uilding, etc. 28f.	24a. Was an autopsy performed Yes 2 one) me 5 Resi	prior to death? 1 V dence 6 Other	nutopsy findings available completion of cause of ves 2 No
n of Vital ling Physician: After this certif	Certification: To Be Completed	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 VER/Outpatient 3 DOA 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office but (Specify) 28e. Place of Injury - At home, farm, street, factory, office but (Specify) 28e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dat one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion,	of Death (Check only of Other; Nursing Hory at Work? 28d. Yes 2 No utilding, etc. 28f.	24a. Was an autopsy performed V Yes 2 when Ye	prior to death? No 1 V) dence 6 Other or Read Number or Read manner as starting to the control of the control	tutopsy findings available completion of cause of ves 2 No
To the Hospital or Attending Physician: The law requires that within 24 hours after death. To the Funeral Director: After this certificate has been signed to completely filled in by the funeral director, page 2 should be detailed.	edical Certification: To Be Completed	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 VER/Outpatient 3 DOA 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined CSpecify) 28e. Place of Injury - At home, farm, street, factory, office but (Specify)	of Death (Check only of Other; Nursing Holy at Work? Yes 2 No uilding, etc. 28f. Ate and place, and due to death occurred at the enumber	24a. Was an autopsy performed Yes 2 one) me 5 Resi Describe how i Location (Stree or Town, State) to the cause(s) time, date and j	prior to death? No 1 V) dence 6 Other or Read Number or Read manner as starting to the start	uttopsy findings available completion of cause of //es 2 No
n of Vital ling Physician: After this certif	Medical Certification: To Be Completed	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 VER/Outpatient 3 DOA 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office but (Specify) 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.	of Death (Check only of Other Work? Nursing Hory at Work? 28d. Yes 2 No uilding, etc. 28f. ate and place, and due to death occurred at the enumber W.E.	24a. Was an autopsy performed Yes 2 one) me 5 Resi Describe how i Location (Stree or Town, State) to the cause(s) time, date and j	prior to death? No 1 V) dence 6 Other njury occurred t and Number or R and manner as statelace, and due to to the death.	utopsy findings available completion of cause of //es 2 No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 19, 2008 11:45 Gabriela Lopez January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 12415 Stonehaven Lane Bowie If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 1)
Mar. 24, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday **Funeral** Months Days 1 □ M 2 1 F Hours 1938 Nicaragua 578-74-7340 69 Director Mar. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f shov Examiner must be notlfied at 1 X Yes 2 □ No Director Maryland | Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20715 USA 12415 Stonehaven Lane by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Hispanic If Yes, Give Year or Dates: 1 X Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced 'natural", Nicaraguan and Mental Hygiene.
is marked other than "natural Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ is marked ot Francisco Hernandez Maria M. Lopez 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 is Maria Lopez/ Daughter 12415 Stonehaven Lane Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Injury or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. 4 □ Donation 5 □ Other (Specify) 1/25/08 Mount Olivet Cemetery Washington, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): physician the as IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the s 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 21 No 1 □ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an rmeg 2 No

Physician

3altimore, Maryland 21215-0036

Completed page 2 s certificate After this funeral

Certification: To Be ofter death.

I Director: Af

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: within 24 hours

To the Funeral Medical

filled in by

State Registrar 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

JAN 2 2 2008

5 ☐ Pending investigation

6 ☐ Could not be

25. Was case referred to medical

1 ☐ Yes

27. Manner of Death 1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

2 No

29c. License number

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at Work?

1 □ Yes 2 □ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1□ Yes

Other: 4 Nursing Home 5 N Residence 6 Other (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one)

cause of death (Item 23a) (Type, Print)

8926 Woodyerd

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

28a. Date of Injury (Month, Day Year)

31. Date filed (Month, Day, Year)

32 Registrar's Signature

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F	lealth and M <i>Death</i>		ene2008	03281
	Dhusisi		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		Elzenia Me	ekins				January	6, 2008	5:05 a M
	Examir		4a. Facility Name (If not institution, give st				or Location of Death		4c. County of Death	
			Genesis Health Car			LaP1a			Charles	
	Funeral Director		231-32-7911	7. Ag	92 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Nov. 13, 1	9. Birthy 915 Warw	place (State or Foreign ntry) ick, Va.
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				I Od. Inside City Limits
	Manyli Pho pro	o.	MD Charles		LaPlata					1 ZYes 2 No
	28a-	ect	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Cou	ntry?
	with so or	ā	1 Magnolia Drive			20646			United St	ates
	heath	era		2. Was Decedent	Ever in U.S. 13.	Was Decedent of I	Hispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No-	14. Race - Americ	can Indian,
980	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23a or 28a-1 ehow the Medical Exarti by routiled at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 反 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2X If Yes, Give Year or Dates:	No	If Yes, specify Cub 1 ☐ Yes 2 ☐ No		Rican, etc.)	Black, White,	
215-0	in 72 ho n "naturi Vedical i	pieted	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most of work d)	ing	6b. Kind of Business/In	dustry
212	d with jiene.	E	Elementary/Secondary (0-12)	College (1-40):		usewife			Domestic	
Maryland 21215-0036	2 should be filed v n and Mental Hygie 'ie marked other t raumatic event, th	To Be C	17. Father's Name (First, Middle, Last) Eligih Tumblin				18. Mother's Name Martha	Scott	aiden Sumame)	
	and 2 shou salth and M n 27 ie mer		19a. Informant's Name/Relationship (Type E.F. Dudley / Gran				and Number or Run O Ct. Wald		City or Town, State, Zip Code) 20602	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examinational Reporting an once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	20b. Place of Disponentery, cre First Bar	matani ar athar ala	ani i		oc. Location - City or To Newport New	
Balti	permit. Departmimporte		21. Signature of Funeral Service License	MO		2. A Te and Address 5538 Ma	ess of Facility_	451	ville, Md.	
	Physician /Medical Examiner	er	23a. Part1. Ener the disense, or complications, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, b.	A/2/ Due to (or as	a consequence of):	ter the mode of dyi		or respiratory arres	st,	Approximate Interval Between Onset and Death
9760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	lical Examiner	If any, leading to minediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):					
O. Box 68	the death certific the attending p ched for use as f	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death 3	⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	y		23d. Date of deliv Month	ery Day Year
ds, P.O.	uires that I signed by Ild be deta	d by Ph	Part II. Other significant conditions cont	ributing to death t	out not resulting in the	underlying cause gr	ven in Part I.		acco use contribute to t	
Records,	hysician: The law requir his certificate has been si I director, page 2 should	ompiete						24a. Was an autopsy perform	prior to co ed? death?	opsy findings available ompletion of cause of
ita		BeC	25. Was case referred to medical	321			26. Place of Deat	h Check only one		
f V	Physician: this certific ral director,	T	examiner? 1 ☐ Yes 2½ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence					ice 6 Other (Speci	fy)
Division of Vital	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	ury 28b. Time o lnjury	Wo	ny at ork?]Yes 2 ☐ No	28d. Describe how	v injury occurred	
Divis	tal or Attures atter de al Directo	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		jury - At home, farm, si tc. <i>(Specify)</i>	treet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rur State)	al Route Number,
	To the Hoepital or within 24 hours after To the Funeral Dirtompletely filled in the completely filled in the completely filled in the formal of the filled in the filled i	Medical			of my knowledge, dea of examination and/or in ated.			red at the time, dat	te and place, and due	to the cause(s)
)	To t To t	Σ	29b. Signature and title of certifier	16	PHYSCHN	29c. Licen	se number	,	d. Date signed (Month.	. Day, Year)
R	(3)		30. Name and address of pers of o cor William Crittenden	npleted cause of 0 9611 J	death (Item 23a) (Type uniper Dri	Print) ve Mitche	llvile Ma	ryland 20	0721	
	St	ate	31. Date filed (Month, Day, Year)	a 32. Regist	rar's Signature					

Registrar

JAN 2 2 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Thelma Moye 8:35 p January 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Clinton Nursing & Rehab Center Clinton Prince Georges If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 6. Sex 1 M 2 T F Months Director 579-42-6513 76 26, 1931 Washington, D.C. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at D.C. 1√□Yes 2□No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with 2512 N. Street S.E. Apt. #4 20019 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. Specify: Black 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Government Mail Clerk 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Taft Moye, Sr. Rhelia Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2512 N. Street S.E. #4 Washington, D.C. Janice Benita Moye /Daughter 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Jan. 18,2008 Suitland, Md. 22. Name and Address of Facility
Alexander S. Pope. P.A.
5538 Mariboro Pike/Forestville, Md. 21. Signature of Funeral Service Line see 20747 Likny Tommena 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SPricut /Medical Due to (or as a consequence of): Examiner Dialit Sequentially list conditions, if a y leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed Exami burial-transi Hyportensia Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical Ca the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 □ Pregnant at time of death 5 ☐ Other (specify) is been signed by the 2 should be detache 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No page 2 After this certificate has autopsy performed 2X No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dana D25640 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7801 Old Branch Ave., Suite 409, Clinton, MD 20735 Khosrow Davachi, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State

DHMH 17 Rev 1/2001

Registrar

JAN 2 2 2008

			For State Registrar		State	of Mai	ryland /	Depa / Cer	rtmen tificat	t of H	ealth a Death	and M	ental Hy	/gieno Reg. No		008	03283
	Physicia /Medic	_	CHIDIEN MAE MILLED										Year 2008	3. Time of Death 2:54 a.M.			
	Examin		4a. Facility Name (If not institution, give street and number)						4b. City, Town, or Location of Death					4c. County of Death			
			5610 Taylor 5. Social Security Number	Road 6. Se		7 400	(In yrs. last	t hirthday)	Rive	rda1	e Par		8 Date of Ri	I I	Prin		orge's place (State or Foreign
	Funeral Director		579-44-9730		M 2 X 0 F		'3	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D			Coui	ntry)
P			Usual Residence of Decedent										12-09-	1934	<u>+</u>		ington,D.C.
arylan	show d at	_	10a. State 10b. Cou	•			10c. City, T										10d. Inside City Limits 1 X Yes 2 ☐ No
he M	28a-f	Director	MD Prince 10e. Street and Number	e Ge	orge's	3	River	dale	Park					10a C	itizen of	What Cou	
with	a or t	ij														771101 000	,
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6 13-0 Ithin 72 ho	Depertment of Heelth and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Dece (Specify only high Elementary/Secondary (0-1		de completed	(1-4or 5+		16a. Deced (Give I life. D	ent's Usu kind of wo OO NOT u	al Occupa ork done d se retired,	ation Juring mos)	st of worki	ng	16b. i	Kind of I	Business/In	dustry
led w	her th		8th 17. Father's Name (First, Mid	do Last				Homen	aker		18 Moth	er'e Name	(First, Middle	e Maide		wn Hoi	ne
d be file	ed of) Be	·	не, Lasij												· .	
should	nd Me mark matic	ပ	Unavailable 19a. Informant's Name/Relati	onship (T	ype. Print)		1	19b. Mailin	g Address	s (Street a		Elsie er or Rura	U: al Route Num	nava ber, City			o Code)
Ma Ind 2 s	elthai 27 Is ertrau		James B. Mil	.ler	Husba	nd	5	610 T	ay1o	r Roa	ad, F	River	dale P	ark,	MD	2073	7
es t	of He fitem rothe		20a. Method of Disposition 1 □ Burial 2 ☑ Cremati	on 2 🗆	Romoval from	n Stata		e of Dispos etery, crem					Date	20c. l	Location	- City or To	own, State
rmit. Pages	ment ant; li lury o		4 □ Donation 5 □ Othe			II State	Metro										Virginia
permit	Import any In		21. Signature of Funeral Services	ice Licens	e . D	asch	Jar						ch's F ue, Hy				P.A. D 20781
			23a. Part1. Enter the disease shock, or heart failure.	, or comp List only (dications that	caused t	he death. I	Do not ente	er the mo	de of dying	g, such as	s cardiac (or respiratory	arrest,			Approximate Interval Between
	ysician	įη	Immediate Cause (Final disease or condition		a	M	yocar	dial	Isch	aemia	a					- 1	Onset and Death
	Medical caminer		resulting in death)		Due to	,	consequen										
		la l	Sequentially list conditions,		b. Due to		onges		Hear	t Fai	llure	!					
nted	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1	c	P	eriph	eral	Arte	rial	Dise	ase					
exec	an an ırlal-tr	Exa	resulting in death) Last		Due to	o (or as a	consequen	nce of):									
cate be executed	physician and s the burlal-transit	dical			.d												
certific	ding p	/Me	IF FEMALE:		23c. If yes, o	utcome p	of pregnance	v							23d F	ate of deliv	verv
The law requires that the death certifi	the atter hed for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			gnant at t	Fetal de ime of deat		Ectopic p Other (s	regnancy pecify)						/onth	Day Year
that th	ed by detac		Part II. Other significant con	ditions or	ontributing to	death but	t not resultir	ng in the ur	nderlying	cause give	en in Part	I.	23e. Did	tobacco	use co	ntribute to t	the cause of death?
yuires	n sign ald be	d by											1.8	Yes	2□ No	3 ☐ Pro	bably 4 □Unknown
law requires	as bee 2 shor	Completed											24a. Wa	s an	240		opsy findings available ompletion of cause of
	cate h	Con												formed? 2⊠ N		death? 1 ☐ Yes	2 No
Or VILCII Physician;	certifi	Be	25. Was case referred to me examiner?	-	Hospital: 4					OA Othe	or:		n (Check only				
	r this ral di	7.	1 ☐ Yes 2 ☑ No 27. Manner of Death		28a. Dat	npatien e of Injury	/ 28	R/Outpatien 8b. Time of		28c. Injun Work	4 (E) N		me 5 Re 28d. Describe	-		_	ify)
VISION	th. r: Afte e fune	tion	1 Natural 5 ☐ Pe 2 ☐ Accident inv	nding estigation		onth, Day	Year)	Injury	м		k? Yes 2.⊑			•			
OIVISION or Attending	after des Directo I in by th	Certification:		uld not be termined	20t. Flat	ce of injur Iding, etc.	ry - At home (Specify)	e, farm, stro	eet, factor	y, office			28f. Location City or T	(Street a	and Nun	nber or Rui	ral Route Number,
L To the Hospital	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical C			niner: On the		examination						and due to th				stated. to the cause(s)
o the	within Fo the comple	Mec	29b. Signature and title of ce	rtifier				<u> </u>	29	c. License	e number			29d. D	ate sigr	ned (Month	, Day, Year)
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2	(4)		30. Name and address of per	son who					Print)								
			Azher Hussai 31. Date filed (Month, Day, Y		- 00	D - 1-4	ala Olamantana		d.,	Colle	ege P	ark,	MD 20	740			
	Sta Registr		JAN 2 2 200		1 32.) J	r's Signatur	de									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** YVONNE A. MAXWELL 01/16/2008 /Medical 5:54 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death PRINCE GEORGES HOSPITAL CHEVERLY PRINCE GEORGES 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 557-34-2251 1□ M 24 F Months Days Hours 84 Director 08/20/1923 LOUISIANA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at MD 1 XYes 2 No Director PRINCE GEORGES UPPER MARLBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20774 10705 ASTORIA DRIVE Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ZNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No 3 Widowed 4 □ Divorced Specify: BLACK 'natural', the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CAFETERIA MANAGER GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be ealth and Mental WILBERT RUSSELL FLORESTINE JOHNSON and I 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau TED SIMON/SON 10705 ASTORIA DR. UPPER MARLBORO, MD 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State RIVERDALE CREMATORY 01/19/2008 | RIVERDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility $J.B.\ JENKINS\ FUNERAL\ HOME$ 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? res 2 Z No this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☑ No 1 🔲 Inpatient 2 ER/Outpatient ۵ 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of After t Certification: 28c. Injury at Work? 28d. Describe how injury occurred or Attending Injury (Month, Day Year) s after de... ••• Director: After 1 Natural 5 Pending 2 Accident investigation M 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

JAN 2 2 2008

WHLE



DHMH 17 Rev 1/2001

Cheverly ND 20785

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Alphonso Mack 17, 2008 January 7:45 P. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Southern Maryland Hospital Clinton Prince Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. (Month, Day, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 M 2 □ F 77 108-24-2843 October 23,1930 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1XYes 2 No Maryland Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16709 Dorchester Place 20774 United States 12. Was Decedent Ever in U.S.
Armed Forces? US Army
1 X Yes 2 □ No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry New York State Elementary/Secondary (0-12) College (1-4or 5+) Government 3 years Civil Engineer 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Alphonso Mack Sallie Livingston Ε. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20774 19a. Informant's Name/Relationship (Type. Print) 16709 Dorchester Place; Upper Marlboro, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
Cheltenham, Maryland Jan. 25, 2008 Maryland Cheltenham Veterans Cemetery R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

permit. Page Department of Important: If any Injury or **Physician**

Injury or

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be in

Hygiene.

d 2 should be fi th and Mental H

ges 1 and 2 it of Health a If item 27 is

Pages 1

"natural", or

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Maryland 21215-0036

Baltimore,

P.O. Box 68760,

Records,

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Physician:

To the Hospital within 24 hours a To the Funeral L

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burial-trar and attending physician for use as the buria detached the by signed I been has Be ပ္ Certification: After death. after death completely filled in by the

Eleanor Grier Mack (Wife) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Spegify) gnature of Juneral Service xarreyal Immediate Cause (Final disease or condition resulting in death) Due o (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or, Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 4☐Pregnant at time of death ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed 25. Was case referred to medical examiner?

Approximate Interval Between Onset and Death BAN 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No 1□ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2€ ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury

5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of ertifie 29c. License number 29d. Date signed (Month, Day, Year)

erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of

MD 701 UNMG

(Month, Day, Year,

JAN 2 2 2008

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27. Manper of Death

102 Natural



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The land L. Mayberty Chemistry Southern Maryland Rospital Southern Maryland Rospital Chemistry									2. Date of Death		3. Time of Death
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Use The Part of the Control of the C		Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)			8. Date of Birth	(ear) 9. Bir	rthplace (State or Foreign country)
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Registrar JAN 2 3 2000 Registrar				JAN 2 3 2008	32. Registrar's Signa	beels	•				

State of Maryland / Department of Health and Mental Hygiene 03287 1 - For State Registrat Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Lucius T. Mangrum 14, 10:53 A^M January 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 5999 Emerson St. #206 Bladensburg Prince Georges If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1√ M 2□ F Yrs. 244-54-3843 74 Franklinton, NC Director May 7,1933 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d, Inside City Limits 10a State 10b County 27 is marked other then "netural", or items 23s or 28e-f show traumatic event, the Madical Exertinal tre notified at ty Yes 2 No MD Prince Georges Bladensburg Direct 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? with 20710 5999 Emerson St. #206 USA death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other then "netural", or Item any injury or other traumatic event, Ite Marical Event Black, White, etc. 1 ☐ Never Married 257 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+) Plumber | Private 6th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Frank Mangrum Harggie Mangrum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Mangrum / Wife 5999 Emerson St. #206, Bladensburg, MD 20710 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Cemetery 1/19/08 Baltimore Maryland `4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy St. NW, Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Arteriosclerosis /Medical Due to (or as a consequence of): **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed attending physician and for use as the burial-transit Heart Disease Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐Pregnant at time of death 5 Other (specify) the a 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ eq Atrial Fibrillation, Diabetes 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2**X** No 1 ☐ Yes 2X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 2 1 XYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: de Hospitel or Atten...
sin 24 hours after death.
"-arel Director: Afte 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0052375 January 18, 2008 Eli3abeth-Dira 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Elizabeth Biru 6525 Belcrest Road Hyattsville, Maryland 20782 31. Date filed (Month, Day, Year) State JAN 2 3 2008 Registrar

8	Physicia /Medic Examin
	Funeral Director

			Registrar		Cer	lilicate of	Death	Reg.	No.	00100
83	Physici /Medic		1. Decedent's Name (First, Middle, Last) Vera Lorraine Matt	hews				2. Date of Death Month 1 / 20 /	⁷ 2008 Year	3. Time of Death 5:00am
	Examin		4a. Facility Name (If not institution, give s Fairfield Nursing H				r Location of Death msville	4c. County of Death Anne Arunde1		
	Funeral Director		5. Social Security Number 578−38−9828 6. Sex	7. Age	(In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 1/21/15	9. Birt Co	hplace (State or Foreign DC
	pu ,		Usual Residence of Decedent		10- 0h. T					140.1.1.100.11.00
	Marylar a-f show ified at	ctor	MD 10b. County Anne Aru	ndel	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 No
	h with the 23a or 28 st be no	Funeral Director	2 10e. Street and Number 2318 Chapel Hill Blvd. 21113					10g.	. Citizen of What Co USA	ountry?
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funer	11. Marital Status 1 Never Married 2 Married 3 Nover Married 4 Divorced	2. Was Decedent E Armed Forces? 1 ☐ Yes 2(3)N If Yes, Give Year or Dates:	0	Was Decedent of H f Yes, specify Cub I ☐ Yes XXXNo	lispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
9	72 hc hatur ical	ted	15. Decedent's Educ	ation	16a. Deced	lent's Usual Occup	ation	16	b. Kind of Business/	Industry
21215-0036	d within 7 giene. er than "r the Med	Completed by	(Specify only highest grade	College (1-4or 5-	life. L	Homemake	during most of workind)	ig	Own Home	e
Maryland	permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other any Injury or other traumatic event, it once.	To Be (17. Father's Name (First, Middle, Last) Joseph Vermillion				18. Mother's Name Alice S		iden Surname)	
	and 2 sho salth and I 27 is ma er traums		19a. Informant's Name/Relationship (Type Alice Sampson	e. Print) Sister		•	and Number or Rura		ity or Town, State, 2n, MD 211	
re	ten Item		20a. Method of Disposition		20b. Place of Dispo cemetery, crer	sition (Name of	ce)	ate 20	c. Location - City or	Town, State
E	Page lent c nt: If ry or		1 ☐ Burial 2 【ACremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Metro Cr			/2008 Ba	altimore,	MD
Baltimore,	permit. Pa Departmen Important: any Injury once.		21. Signature of Funeral Service Lanse	e			ess of Facility Har			
ũ	permil Depar Impor any Ir once.		> 1/2 12. CM			2 Ridgely			, MD 2140	
	Physician		23a. Part1. Enter the disease, or complications shock, or heart failure. List only on Immediate Cause (Final	cations that caused e cause on each line	- O			r respiratory arrest	,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	-	consequence of):	euma	7694			
	Examiner			Seemer						
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ox (The law requires that the death certificate be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	n/Medical	IF FEMALE:	3c. If yes, outcome p	of pregnancy				22d Date of do	livon
Bo	atten for u	ian	in the past 12 pronths?	1□Live birth 4□Pregnant at	2 ☐ Fetal death 3 ☐	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	Day Year
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P.0	s that the death ned by the atter s detached for u		Part II. Other significant conditions con	tributing to death bu	t not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tobac	co use contribute te	o the cause of death?
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or Vital Records,	w requires that been signed I should be det	Completed by								
Sec.	'slclan: The law s certificate has t irector, page 2 s	ď						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
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/ita	Physician: r this certifica ral director, I	Be	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)		
-	Physic this c	ပ	1 □ Yes 2 No	ospital: 1 🔲 Inpatier	nt 2 ☐ ER/Outpatier		4 Nursing Ho	me 5 Residenc	ce 6 □Other (Spe	ecify)
П	dlng PI. After ti funera		27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time o Year) Injury	28c. Inju Wo	ry at :	28d. Describe how	injury occurred	
Division	endl sath. or: A he fu	atic	2 ☐ Accident investigation			M 1□	Yes 2 □ No			
Ξ	r Att	ij	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of inju building, etc	ry - At home, farm, str . (Specify)	eet, factory, office		28f. Location (Stree City or Town, 3	et and Number or R State)	ural Route Number,
	talors aft all oral oral oral oral oral oral oral	Certification:								
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) Check only one) Check only 2 Medical Examin	ician: To the best oner: On the basis of and manner sta	f my knowledge, deat examination and/or in ted.	n occurred at the ti vestigation, in my	me, date and place, opinion, death occur	and due to the cau red at the time, date	se(s) and manner a e and place, and du	s stated. e to the cause(s)
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 15, 2008 January 4:05 P M Dora Mohamed /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges 9211 Chestnut Ave. Bowie 8. Date of Birth (Month, Day, Year)
Jan. 28, 1919 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday, **Funeral** West Indies Months Days Hours Min 1 □ M 2 🗓 F 88 **Director** 116-76-9731 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State r 28a-f show notified at 1 XYes 2 No Director Prince Georges Bowie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or 20720 USA 9211 Chestnut Ave. r than "natural", or items 23a the Medical Examiner must Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ XNo **Black** Baltimore, Maryland 21215-0036 Specify: Specify: þ 3 Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Midwife Medical permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other i any injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virginia Hercules Philip Edwards 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9211 Chestnut Ave. Bowie, MD 20715 Debra Moore/Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Lakemont Memorial 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 1/21/2008 Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) Gardens 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licens 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ms **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a challequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Day Year in the past 12 months? signed by the a d be detached f 2 X No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Insular dependent. Hypertens -non 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 1 No boulation 24a. Was an autopo performed ne 2 No Pailwe 1∐ Yes or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 Natural 2 Accident Injury 5 □ Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Whitagi mo 024120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAVINDER K. RUSTAC/ MD 6/32 LANDOVER ROAD, CHEVERLY MD 20785

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JAN 2 2 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03290 Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Day Physician MAKOFSKI 705 PM STEPHEN R. JANUARY 2208 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 600 NORTH WOLFE STREET None If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 16, 19 9. Birthplace (State or Foreign Country) Maryland Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Hours Months Days 1X M 2 □ F Yrs. 1960 47 Director 219 74 1630 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ims 23a or 28a-f shi ir must be notified a 1 ☐ Yes 2 XNo Director MD Columbia Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 9020 Watchlight Court 21045 United States Funeral Race - American Indian, Black, White, etc. Items ; 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married , or 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced White "natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Monce. Self Employed 5+ Musician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert A. Makofski Lillian M. Zapora 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9438 N. Penfield Road Columbia, MD 21045 Lillian M. Makofski/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 1-25-2008 Clarksville, MD 4 Donation 5 Other (Specify) Columbia Mem. Park 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA ASPIRATION DAVS /Medical Due to (or as a consequence of): Examiner PARALYSIS MONTHS VOCAL LORD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed CARCINOMA Saymous CELL THE LUNG 7 MONTHS OF and Due to (or as a consequence of): physician SMOKING 20 YEARS Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? φ WALL CELLULTIS ABDOMINAL 1 XYes 2 No 3 Probably 4 Unknown Completed PARANOID 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ◯ No 9CHIZOPHRENIA autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X**No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Il Director: / 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide

within 24 hours a To the Funeral I 100

Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

IVAN HAMILTON 31. Date filed (Month, Day, Year) State

Medical

29a, Certifier

29b. Signature and title of ce

JAN 24

600 NORTH WOLFE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

and manner stated.

MD

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0063437

BALTIMORE

29d. Date signed (Month, Day, Year)

JANUMPY

21287

MD

21

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Carol Ann Maiello /Medical 4a. Facility Name (If not institution, give street and number)
Carroll Hospital Center 4b. City, Town, or Location of Death
Westminster 4c. County of Death Examiner Carroll 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🛣 F 022-26-4824 72 May 21, 1935 Director Massachusetts Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland Carroll Westminster 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ៦ 21157 USA 121 West Main Street or items 23a 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: white Completed by 3 ☐ Widowed 4 MDivorced "natural" 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Hospital 5+ Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna McNally John S. Philpott ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 121 W. Main Street, Westminster, MD 21157 Edward J. Maiello, son 20b. Place of Disposition (Name of South, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State Pages 1 Department of important: If it any injury or o 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Carroll Crematory 1/19/2008 4 ☐ Donation 5 ☐ Other (Specify) Winfield, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Mvers-Durboraw Funeral 91 Willis Street, Westminster, MD 21157 tari 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BRONCHIOLITIS OBLITERANS ORGANIZING **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Due to for as a consequence of Examine any, reduing to mini solute cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of): Box 68760. attending physician requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) P.0. signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy perform this certificate 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 1 Inpatient 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 2 Accident Injury 5 Pending investigation 1 □ Yes 2 □ No spital or Attendi nours after death. neral Director: A filled in by the fu death. 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital c within 24 hours aff To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WIL

State Registrar

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FRANCIS

31. Date filed (Month, Day, Year)

Memorial

30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt)

2008

200 32. Registrar's Signature

Khoo

30263

Westminster MD 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 21 **Physician** John M. McLaughlin Month 12:05 PM Vanuary 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner La PLata CIVISTA MEDICAL Center HARLES If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days 1 MM 2 □ F Director 147-22-2842 May 1, 1930 NJ Usual Residence of Decedent 10a State 10c, City, Town or Location 10d. Inside City Limits r 28a-f show notified at MD Charles Waldorf Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? an "natural", or items 23a or Medical Examiner must be 3103 Freedom Crt. So. 20603 Charles Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ∏ Yes 2 □ If Yes, Give Year or Dates: ^{2□}N₀952-1956 1 ☐ Never Married 2 ☑ Married 5-0036 1 ☐ Yes 2 ☑ No Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 21 Elementary/Secondary (0-12) College (1-4or 5+) Sales Representative Furniture 2 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If Item 27 Is marked o Martin McLaughlin Ada Swift McLaughlin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary McLaughlin/Wife \$103 Freedom Crt. So. Waldorf, Md. 20603 Baltimore, important: If item any injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \$t. Joseph's Cem. 1/26/2008 4 Donation 5 Other (Specify) Pomfret, Md. 21. Signature of Funeral Service Licensee AREHART-ECHOLS FUNERAL HOME, PA MO0945 Warn Box 567 LaPlata, Md. 20646 P.O. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a consequence or disecise disease or condition resulting in death) teans /Medical **Examiner** hyperlipide unia Year Sequentially list conditions, Examiner any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by with metastatic cell caranina 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? res 2 No certificate anemia xwandary or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death Check onl one Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ca (co

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State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CasTRENCE MD 12070 OLD LINE CENTRE Ste 100 Waldorf Md 2002 C.

> Goarle Clour 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 8:38 AM R. McIlvain Cornea 01 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner Wicomic HOSQ ce at Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Months Days Hours Min. 1 ☐ M 2 🕱 F 78 Director 197-22-1224 3/8/1929 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐XNo Director Millsboro Delaware Sussex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19966 USA 407 Amberly Court Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married アカピネー // 1.C ナラロイン altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Š 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Esther Geyer Clyde Sterner ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 407 Amberly Ct., Millsboro, De 19966 Steven E. McIlvain/son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Susquehanna Memorial 20c. Location - City or Town, State 20a, Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/26/08 York, PA 4 ☐ Donation 5 ☐ Other (Specify) Gardens Sunature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Jarrie H. Dompoor CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final OVARIAN CARCINDUMA **Physician** MRTASTATIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, and a graph of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 6 No 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 【■No 24a. Was an autopsy performed? Yes 2 12 No 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Mapatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To After this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) Natural 2 ☐ Accident 5 ☐ Pending investigation s after dea... ral Director: Aft 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide completely filled in by 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ertifier

State Registrar HOSPICE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

COASTAL

strar's Signature

WARW

Year)

Humin

31. Date filed (Month, Day,

D0058410

P.O Box 1733 SHUSBURY up 2/802

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Deborah Jean Manning 30 AM January 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner <u>Washington</u> Washington County Hospital Hagerstown 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2 7 F Director 217-56-0970 56 November 11,1951 W Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natura!", or items 23a or 28a-f show edk al Examiner must be notified at 1 XYes 2 □ No Directo MD Washington Hancock 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21750 **USA** 6 West Main Street Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White 3 ☐ Widowed 4 ☐ Divorced ear or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Manufacture Seamstress of Health and Mental Hygie I Item 27 is marked other r other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cecil Murphy H. Fern McQusker ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) H. Fern Hart/Mother 216 Stone Valley RD Warfordsburg, PA 17267 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Hagerstown Crematory 01/29/2008 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, MD 22. Name and Address of Facility Grove Funeral Home 21. Signature of Funeral Service Licensee 141 W. Main St., Hancock, Maryland 21750 23a. Part1. Enter the disease, or complections that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Morbid Physician /Medical Due to (or as a consequence of): Hypoventilation Examiner Sequentially list conditions Examiner in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed Obstructive attending physician and for use as the burial-tran-Due to (or as a consequence of) Division or Vital Records. P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) ed by the a 1 □ Yes 2 □ N/6 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Urhknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has I autopsy performed? After this certificate 2 □ No 1□ Yes funeral director. 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Depatient 3□ DOA 2 ER/Outpatient 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours at To the Hospital 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1060396

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

31. Date filed (Month, Day, Year)

FEB 06

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 31, 8:45 Harriet Marie Mikulan January 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford Hours Min. 8. Date of Birth (Month, Day,) 8/9/1921 Birthplace (State or Foreign Country) Pennsylvania Pennsylvania Pennsylvania Pennsylvania Pennsylvania Pennsylvania Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🔀 F 86 173-16-7310 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County iral", or items 23a or 28a-f show Examiner must be notified at XXYes 2 □ No Harford Bel Air Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 912 Autumn View Ct. 21014 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ➡ No þ Specify: 3 Widowed 4 Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hairdresser Self employed 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Claude Vern Williams Freda Henrietta Burchardt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Bel Air, MD permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr. once. Claudia Nimmo (Daughter) 912 Autumn View Ct. 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) R. A. Ferris & Co. 2/1/08 West Chester, PA 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 21. Signajure of Funeral Service Licenses 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of a ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and Examin burial Records, P.O. Box 68760, physician s the burial Physician/Medical attending pl for use as t IE FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an was autopsy performed? 1□ Yes Division or Vital 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital No De 1 ☐ Yes Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Monter of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

FEB 06 2008

ddress of person who completed

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ause of death (Item 23a) (Type, Print)

29c. License number

Havre de Grace

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State	State of Mar	-	epartment of I Certificate of		•	0000	00000
		-	Registrar 1. Decedent's Name (First, Middle, L	ast)		Jertinicate or	Dealii	2. Date of De	Reg. No.	3. Time of Death
	Physicia /Medic	_	Quyen Dieu Nhi	eu				Month Janua	ry 21, 2008	6:22 a M
	Examin	-	4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town,	or Location of De	eath	4c. County of Dea	th
	<u> </u>		Kensington Nurs	ing & Rehab.	In up lost hirth	Kensi	ngton I fi Under 24 H	rs. 8. Date of Bir	Montgon	nery thplace (State or Foreign
4	Funeral Director		5. Social Security Number 6. 215–33–7468	1 DM 2 N E	In yrs. last birtl	rs. Months Days			9, 1935	thplace (State or Foreign ountry) Vietnam
<u> </u>	to	}	Usual Residence of Decedent						, , , , ,	
	arylan show d at	_	10a. State 10b. County] 1	0c. City, Town	or Location				10d. Inside City Limits 1 ☐ Yes ※XX No
	he Ma 28a-f	Directo	Maryland 10e. Street and Number	Montgomery	Gai	thersburg			10g. Citizen of What Co	
	with a		8124 Langport	Terrace		20877	•		USA	Surray :
	death	Funeral	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. Was Decedent of If Yes, specify Cul	Hispanic Origin?	(Specify Yes or No	14. Race - Ame Black, Whi	
5-0036	be filed within 72 hours after death with the Maryland Hylgiene. Hylgiene. dother than "natural", or items 23a or 28a-f show dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2☐ Married 3 ☐ Widowed 4 ☐ Divorced			1 ☐ Yes 2 X M No		erto riicari, etc./	Specify:	Asian
2-0	72 he "natu dical	letec	15. Decedent's (Specify only highest of	Education grade completed)	16a. I	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of v	working	16b. Kind of Business	/Industry
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<u>q</u>	should be filed and Mental Hygi marked other matic event, ti	Be Co	17. Father's Name (First, Middle, La.	st)		110memaxe1	18. Mother's N	łame (First, Middle	, Maiden Surname)	
<u>lan</u>	ould be i Mental arked o atic eve	P B	Unknown				Unkno	own		_
ਕ	S ar		19a. Informant's Name/Relationship	(Type. Print)	19b.	Mailing Address (Stree	t and Number or	Rural Route Numb	er, City or Town, State,	Zip Code)
as	1 and 2 Health tem 27 I		Tony Co/Son 20a. Method of Disposition		81	24 Langpor	t Terrac		ersburg, MI 20c. Location - City or	
altimore,	permit. Pages 1 Department of F Important: If Ite any Injury or ot		1 ☐ Burial 2√☐ Cremation 3			Disposition (Name of c, crematory or other plants		an. 27,		
를	nit. Parantme prtant prtant Injury		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	**	месторс	litan Crem	7			a, Virginia
Ba	Dep Imp		10000	Order.					1 Home Inc. Silver Spri	ng, MD 20901
53.	-110		23a. Part1. En er the disease, or co shock, or heart failure. List on	mplications that caused the	ne death. Do n					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			Disease				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence o	f):				
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	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
ó	an and rial-tra		resulting in death) Last	Due to (or as a	consequence o	f):				
58760,	icate be executed physician and s the burial-transit	edical		d						
			IF FEMALE:	23c. If yes, outcome pf	pregnancy				23d. Date of de	divon
P.O. Box	Physician: The law requires that the death certifute certificate has been signed by the attending rail director, page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су		Month	Day Year
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S,	uires that the de signed by the a Id be detached f	by P	Part II. Other significant conditions	s contributing to death but	not resulting in	the underlying cause g	iven in Part I.		tobacco use contribute t	
Records,	w requir been si should	Completed						- I-2.	Yes 2 No 3 P	
3ec	has by	mple						– 24a. Was	s an 24b. Were a prior to commed? death?	utopsy findings available completion of cause of
a	sician: The certificate har rector, page		25. Was case referred to medical	1			OC Place of F	1 Yes Death (Check only	2 No 1 ☐ Ye	
5	yslcla is cert directe	o Be	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Out	patient 3 DOA	thor:		idence 6 □Other (Spe	ecify)
Division or Vital	ding Phy n. After thi funeral	-	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	28b. T	ime of 28c. Injury			how injury occurred	,
Sio	Attending ir death. ector: After by the fune	catic	2 Accident investigate 3 Suicide 6 Could not	bo	A11 6		Yes 2 No			
<u> </u>	I or At after d Direct I in by	Certification:	4 ☐ Homicide determine		(Specify)	m, street, factory, office	,		(Street and Number or R wn, State)	turai Houte Number,
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical C		Physician: To the best of aminer: On the basis of e	xamination and					
	To th within To th	Me	29b. Signature and title of certifier	an	41.		nse number		29d. Date signed (Mon	
	7/		indles		1410	Di	06462	-4	January	22, 2008
			30. Name and address of person who Sandeep Sharma,			Type,Print) Nalk Drive,	Gaithe	rsburg, M	D 20878	
E	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 3 2	32 Registrar	s Signature	Conti				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03297 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** January 19, 2008 Marguerite Diane Nicol 6:50 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Glenn Dale Prince George's 10708 Javins Street If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Davs | Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Director 380-24-5873 78 Michigan 24, 1929 Aug. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b County 10d. Inside City Limits show Department of Health and Mental Hygiens "returned source occurs with the yearly important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. ty∑Yes 2 □ No Director Glenn Dale Maryland Prince George's 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20769 USA 10708 Javins Street death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If Item 27 Is marked other than "natural", or Ite 1 □ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Cheese Sales Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Angelina Steiner ALfred Ristdow 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10708 Javins Street Glenn Dale, MD 20769 William A. Nicol/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 1/22/2008 Alexandria, VA Crematory 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee A Face 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 4 m /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 14 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performe death? 2 No To the Hospital or Attending Physician: the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 🗆 N Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Watural 5 Pending investigation death. 2 Accident within 24 hours after death To the Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 12 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and tiple of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8926

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JAN 22

31. Date filed (Month,

		-	For State Registrar	State of Mai	•	epartment of t Certificate of		, ,	giene Reg. No. 2	108	03298
	Dhariai		1. Decedent's Name (First, Middle, La	st)				2. Date of Dea Month	Care Vi	Year	3. Time of Death
	Physicia /Medic	al -		ATES JR.				1/16/	/2008	Teal	12:45 a ^M
	Examin	er	4a. Facility Name (If not institution, giv				or Location of Death		4c. Count		•
		300	SOUTHERN MARYLA 5. Social Security Number 6. S		(In yrs. last birth	CLINTO		8. Date of Birth	PRINC		
dip	Funeral Director		577-52-0565	₩ 2 F	68 Yr	Months Days		(Month, Day 1/19/	, Year)	Penns	lace (State or Foreign htry) S ylvania
	ryland how	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town of	or Location				1	0d. Inside City Limits
	ne Ma 8a-f s atifiec	Director		GEORGE'S	TEMPLE I						1 X Yes 2 □ No
	with the	ä	10e. Street and Number			10f. Zip Code	•		10g. Citizen of	What Cour	ntry?
	leath ns 23 must	Funeral	2513 Fairlawn S	12. Was Decedent Ev	ver in U.S.	20748 13. Was Decedent of I		ecify Yes or No-	USA 14. Ra	ce - Americ	an Indian,
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If them 27 Is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fun	1 □ Never Married 2 ▲ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 X Yes 2 No If Yes, Give)	 Was Decedent of I If Yes, specify Cub Yes 2 No 		Rićan, etc.)		ick, White, fy: AFR1	etc. CAN AMERIC
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<u> </u>	should be ind Mental marked umatic ev	၉	ROBERT L. OATES S				RUTH RIC				
Maryland 21215-0036	d 2 sh thand 7 Isrr traum		19a. Informant's Name/Relationship (PATRICIA OATES/W		1	Mailing Address (Street 3 FAIRLAWN					
	1 and Healt em 2		20a. Method of Disposition	LT D	20b. Place of D	Disposition (Name of		Date	20c. Location		
E E	Pages nent of I int: If Its iry or o		1 Burial 2 □ Cremation 3 □ 4 □ Donation ■ □ Other (Specia		1	crematory or other pla MEMORIAL		4/2008	LANDOVI	-	
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		21. Signature of Tuneral Service Lice	nsee		22. Name and Addre	•	LANDOV	ER, MD	2078	5 PD
			23a. Parti. Enter the disease, or comshock, or heart failure. List only	plications that caused t	he death. Do no	The state of the s				idove	Approximate
	Dhusisian		shock, or heart failure. List only Immediate Cause (Final	one cause on each line	1.		0.	, , , , , , , , , , , , , , , , , , , ,			Interval Between Onset and Death
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	Examiner			200 10 (0) 40 4	oonooquonoo on						
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, it	edical (29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of and manner state	examination and/	death occurred at the too for investigation, in my	time, date and place opinion, death occu	, and due to the orred at the time,	cause(s) and n date and place	nanner as s	stated. o the cause(s)
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State 31. Date filed (Month, Day, Year) 32. Rustrar's Signature		8					cause of death	(Item 23a) (Type, Print) J COUR	IT SU	ITE 102	WALDOF	RF, M	D. 20	602	
I I I I U U E V V I METABULA AV ANDE	6			31. Date filed (Mon	th, Day, Year)	3		Signature _	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03300 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician 4:08 P M FLORENCE 0. PAIGE JAN. 21 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Hospice Center BALTIMORE BATLIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 2, 1915 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 X F 92 Virginia Director 579-32-4451 Usual Residence of Decedent with the Marylan 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at VA Fauguier Upperville 1 Yes 2 □ No Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code must be r 9265 Patrick Street 20184 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 'natural', or iter dical Examiner 2 should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑No Specify: Black þ 3℃ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) C & P Telephone Elementary/Secondary (0-12) College (1-4or 5+) Office Tech 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 7 is marked of traumatic even Charles Kenny Mildred Briscoe P Pages 1 and 2 should nent of Health and Mer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If Item 27 is any Injury or other tra once. 9265 Patrick Street, Upperville, VA 20184 Helen Carr (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Domation 5 Other (Specify) Milton Valley Cem 1/26/08 Berryville, VA 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service Licens 246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the di ase, or mp ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death prokin son Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examin The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA P 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner_of Death 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title dertifier 29c. License number 25205 N. Charles St. Balto. Md 2,20%

Registrar DHMH 17 Rev 1/2001

State

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January 21, 2008

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Day,

31. Date filed (Month,

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32. Registrar's Signature

			For State Registrar	State of Ma		partment of I ertificate of		d Mental Hy	/giene Reg. No.	0000	03301
9		•	Hegistrar Decedent's Name (First, Middle, Last)					2. Date of D	eath		3. Time of Death
	Physicia /Medic		Carlyn B. Pitts			·		Januar	y 21	2008	03:10 A M
	Examin	er	4a. Facility Name (If not institution, give s			4b. City, Town, o		eath		County of Deatl	
4		ti,	Anne Arundel Medica 5. Social Security Number 6. Sex	7. Age	(In yrs. last birthda	Annapol:		Irs. 8. Date of Bi	irth	nne Arun	nplace (State or Foreign
	Funeral Director		577−34−4787 1 [□]	M 2XIF	81 Yrs.	Months Days	Hours M		1927	Wash	ington, D.C.
	put "		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	ocation					10d. Inside City Limits
	//aryla	or	Maryland Anne Aru	ndo1	Deale						1 □Yes 2 XNo
	r 28a-	Director	10e. Street and Number	idei	Deate	10f. Zip Code			10g. Citi	izen of What Co	untry?
	th with	al D	5936 Sneed Drive			2075	51		Unit	ted Stat	es
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ∐Yes 2 XN If Yes, Give		B. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☒ No	an, Mexican, Pu	(Specify Yes or Nuerto Rican, etc.)	0-	14. Race - Amer Black, White	
0000	ours a	d by	3 ☐ Widowed 4 🔏 Divorced	Year or Dates:						Specify: Bla	
ה	"natu	Completed	15. Decedent's Educ (Specify only highest grade	cation e completed)	16a. Dec	edent's Usual Occu ve kind of work done . DO NOT use retire	pation during most of (working	16b. Ki	ind of Business/l	Industry
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ס פ	Hygi Hygi other ent, t	Be C	17. Father's Name (First, Middle, Last)				1	Name (First, Middle			
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Mary	2 sho and I is ma		19a. Informant's Name/Relationship (Type			iling Address (Stree					,
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	ages 1 If ite		20a. Method of Disposition 1 Burial 2 Cremation 3 R	emoval from State	cemetery, c	rematory or other pla	i			•	
altimor	artmel		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service License	9e / / »	Kalas C	rematory 22. Name and Addr	ess of Facility C	21/2008	Edge	ewater,	Maryland
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	sIcian: The law certificate has b irector, page 2 sh	duo						— aut	opsy formed,?	prior to death?	completion of cause of
NIG	lan: Trifical	Be C	25. Was case referred to medical				26. Place of I	1 Yes Death (Check only		1 10163	2 140
	hyslc his ce	To E	examiner? 1 ☐ Yes 2 No	lospital: 1 💢 Inpatie	nt 2 ☐ ER/Outpat	ient 3 DOA O1	her: 4 🗆 Nursin	g Home 5 ☐ Re	sidence	6 □Other (Spe	cify)
DIVISION OF	ing P		27. Manner of Death 1 ★Natural 5 □ Pending	28a. Date of injur (Month, Day		/ Wo		28d. Describe	how inju	ry occurred	
S	death.	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e Place of init	ry - At home, farm,		Yes 2 No	28f Location	(Street ar	nd Number or Ri	ural Route Number,
2	tal or A s after al Direc ed in by	Certification:	4 ☐ Homicide determined	building, etc	. (Specify)			City or T	own, State	e)	and troute trained,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	dical	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Exami	ner: On the basis of and manner sta	examination and/or ted.	investigation, in my	opinion, death o	occurred at the time	e, date an	d place, and due	s stated. e to the cause(s)
)	To t With: To t	M	30. Name and address of person who continued the second se	in Bech, o	40	29c. Licen	Se number 74605	2	29d. Da	ite signed (Mont	
6	40		30. Name and address of person who co	ompleted cause of de	eath (Item 23a) (Typ	e, Print) Parke	Jay a	nhapolis	, MG)	
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Registrar DHMH 17 Rev 1/2001

10+VA State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

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Registrar

Washington St.

Easton, MD ZIGOI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		,	For 1 _ State	State of	Marylan			nt of He te of E		and Me	,	_ ^		000	0.0
	~		Registrar 1. Decedent's Name (First, Middle, Li	ast)		Oe1	uncai	OI L	Jeani	2	. Date of De	Reg. No	:UUB_	3. Time of	ل ل f Death
	Physici /Medic		COLLEEN LOUISE	RATIGAN							Month JANUAR	Da		4:40	A M
1	Examin	150	4a. Facility Name (If not institution, gi	ve street and num	ber)		4b. City	, Town, or	Location o				. County of Death		
			NATIONAL INSTITU			to a definite of a con-		THESD	A If Under 2	24 Uro o			ONTGOMER		
	Funeral Director			Sex 7 1 □ M 2 ☑ F	'. Age (In yrs. 42	rast birthday) Yrs.	Months		Hours	Min,	Date of Bir (Month, Da	ay, Year)	9. Birth Cou	place (State ontry)	or Foreign
420	oline pe milita ele		Usual Residence of Decedent							<u></u> U	ec. I	/ , 1	JUJ Call	IUIIIIA	
	arylan show d at	_	10a. State 10b. County			y, Town or Lo	cation							10d. Inside C	ity Limits
	the Ma 28a-f	ecto	NJ Bergen 10e. Street and Number		Lodi	<u> </u>	1405 7	0 1				10- 00			21110
	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. A filem 27 is marked other than "natura", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral Director	200 Bell Avenue					Code 644				USA	izen of What Cou	ntry r	
	death	nera	11. Marital Status	12. Was Deced	lent Ever in U.	S. 13. V	Was Dece	dent of His	spanic Orig	gin? (Specif	fy Yes or No can, etc.))-	14. Race - Americ		
36	s affer or ite	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give	2 ⊠ No		1 ☐ Yes		Specify:	, rueno ni	ball, etc.)		Black, White, Specify: 1.1		
21215-0036	hour tural'	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E	Year or Date	ies:	16a, Deced	dent's Usu	al Occuna	tion			16h K	ind of Business/In	hite	
215	in "na in "na Medic	Completed	(Specify only highest gi Elementary/Secondary (0-12)		4or 5+\	(Give life. L	kind of wo	ork done di se retired)	uring most	of working			kensack		ian
21	ed with	Com		4 yrs	,	Art 7	Геасh					Sch			
Maryland	ntal H ed oth ed oth	Be	17. Father's Name (First, Middle, Las Charles Ratigan	t)							First, Middle		Surname)		
ry i	nould marke matic	스	19a. Informant's Name/Relationship	(Type, Print)		19b Mailin	na Address	s (Street a		-			or Town, State, Zij	n Code)	
Z	1 and 2 s Health ar tem 27 is other trau		Shirley M. Martu			P.O.	-			rey,		3452	71 10WH, Olato, 24	0000)	
ore,	es 1 a of Hear ir othe		20a. Method of Disposition	70		Place of Disportenetery, cren	sition (Na	me of	e) ;	Dat	e	20c. Lo	ocation - City or To	own, State	
	Pages ment of tant; If its lury or o		1 ☐ Burial 2 ဩ*Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		Met	ropoli	tan (Cremat	tory	01-22-	-2008		xandria,		
Ball	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr		21. Signature of Funeral Service Lice	h oh all	(/								neral Ho on, DC	me, in 20011	ic.
			23a. Part1. Inter the disease, or cor shock or heart failure. List only	nplications that ca	used the death								11, -0	Approximat	te
F	hysician		shock/or heart failure. List only Immediate Cause (Final disease or condition		ch line.									Onset and	Death
7	/Medical		resulting in death)		r as a consequ		4100	^						24	5012
Se.	Examiner	_	Sequentially list conditions,	b											
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a consequ	uence or);									
o,	exect an and riaf-tra	Еха	that initiated events resulting in death) Last	C Due to (o	r as a consequ	uence of):									
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical	•	d											
× 65	ding pl	/Med	IF FEMALE:	23c. If yes, outco	ama of progna										
Вох	attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bir	th 2 ☐ Feta nt at time of d	Ideath 3 □	Ectopic p						23d. Date of deliv Month	,	Year
P.O.	t the c by the achec	hysi	1 ☐ Yes 2 🔼 No 9 ☐ Unknown	9□Unknov				,,							
S, F	w requires that the dibben signed by the should be detached	by P	Part II. Other significant conditions	contributing to dea	ith but not resu	ulting in the ur	nderlying o	cause giver	n in Part I.				use contribute to t		
ord	een si	ted						-			1 🗆	Yes 2	No 3 Pro		
Vital Records,	hasb je 2 s	Completed							_		24a. Was auto		24b. Were auto prior to co death?	opsy findings impletion of c	available cause of
tal	certificate h		25. Was case referred to medical						26 Place	of Death //	12 Yes	2□No		2 ⊠ No	
>	S 5	To Be	examiner? 1 ☐ Yes 2 📉 No	Hospital: 1 🗖 In	patient 2 🗆	ER/Outpatien	t 3 D	Othou	r.		Check only only only on the single of the s		6 □Other (Speci	fv)	
0 0	After thi		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of	Injury , Day Year)	28b. Time of Injury		28c. Injury Work			d. Describe			2/	
sio	Attending r death. ector: After by the fune	catio	2 Accident investigation				М		es 2□N						
Division or	r te	Certification:	4 ☐ Homicide determined	28e. Place of building	of injury - At ho g, etc. <i>(Specif</i>)	ome, farm, stre	eet, tactor	y, office		281	City or To		nd Number or Run e)	al Houte Nun	nber,
-	vithin 24 hours after or To the Funeral Dir. completely filled in the			hysician: To the b											
	vithin 24 hours To the Funeral completely filled	Medical	one)	miner: On the bas and manne		tion and/or in				in occurred	at the time,			`	s)
		2	29b. Signature and title of certifier	1			1	c. License					te signed (Month,	-	
	To with		Madriht	anla			ī	700	bli 6	LLX		70	017	7 00%	
	E SE		Manuel 30 Name and address of person who		of death (Item	23a) (Type		200	646	48		20	n 17,2	2008	
2 (Son of wife		30. Name and address of person who MAHSA MOHEBTAS	completed cause			Print)						20892	2008	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Anthony Alexander Merino Rubio January 21 2008 10:40 A M /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 805 Hobbs Dr. Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 2 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 M 2 □ F 15 El Salvador 1993 215-67-9652 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1√ Yes 2 No Silver Spring Director Maryland Montgomerv 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 805 Hobbs Dr. 20904 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Never Married 2 ☐ Married filed within 72 hours after ம் Yes 2□No Specify:Salvadorian Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) and Mental Hygiene. Elementary/Secondary (0-12) Public School Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be pe Merino Rubio Efrain Maria Pages 1 and 2 should or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Rubio 805 Hobbs Dr. Silver Spring, MD 20706 item 27 is (Mother) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If ite any injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate Of Heaven Cemetery 1/23/08 Silver Spring, MD eral Service Licensee 21. Signature 🥩 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. mediate Cause (Final Cardiorespiratory Arrest **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Glioblastoma With VA shunt S/P Debulking Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Cerebral Palsey/ optic glioma burial-tran Due to (or as a consequence of): Dumping Syndrome Physician/Medical the IF FEMALE nse 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Medical Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural 2 Accident 5 ☐ Pending investigation within 24 hours at er dea h.

To the Funeral Lirector: A completely filled i by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician:

State

DHMH 17 Rev 1/200

31. Date filed (Month, Day, Yea JAN 2 2 2008

29b. Signature and title of certifier



29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1 - State Registra MFND#4 coerMD1/23/08, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** ROZACID othy Juliana 2032 M 01 20 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince **Examiner** ¿George's HUS Pital egio ral Laurel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 26, 1936 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Bangladesh Social Security Number **Funeral** 1 □ M 2 🔀 F 212-79-3057 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Maryland Prince George's Beltsville 1 □ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20705 4234 Kenny Street Bangladesh Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Bangladeshi Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. 2 3 XWidowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (2-12) College (1-4or 5+) Housewife own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Augustine Rozario Antonia Rozario ည 19a. Informant's Name/Relationship (Type. Print)
Daisy V. Costa- daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4234 Kenny Street Beltsville, Maryland 20705 Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State St. John the Baptist Cem. 1/31/2008 Gazipur, Bangladesh 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service Licen Le DốnaTrandvieBorgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 1est cerebral **Physician** Large /Medical Due to (or as a consequence of) **Examiner** ertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Gastro esophagea Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No MYD Cardial Infarction 24a. Was an autopsy 2₽No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Jan 20, 2008 000 43662

State Registrar

31. Date filed (Month, Day, Year) JAN 23

WIJAM



LAUREL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Boy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 _ State	artment of Health and Me		_ZUUĞ UJJUD
	91	Registrar 1. Decedent's Name (First, Middle, Last)		Reg. N . Date of Death	3. Time of Death
. Physic		Flossie Mae Robinson	J	Month D	8, 2008 17:05 P ^M
Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
The second second		Southern Maryland Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Clinton If Under 1 Year If Under 24 Hrs. 8	. Date of Birth	Prince George's 9. Birthplace (State or Foreign
Funeral Director		579-36-6632 1□M 2√2 81 Yrs.	Months Days Hours Min.	(Month, Day, Yea	r) Country)
D		Usual Residence of Decedent		111 20,	
larylar show	2	10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits 1 XYes 2 □ No
the N 28a-f notifie	Director	Maryland Prince George's Chelten 10e. Street and Number	ham 10f. Zip Code	10g. C	Citizen of What Country?
h with 23a or st be		10210 Rockview Terrace	20623	1	United States
r deat ems 2	Funeral		Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Richard Control of the Control o	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc.
Ind 21215-0036 be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes ※☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		African Specify:
5-0036 72 hours af hatural", or dical Exam	led	15. Decedent's Education 16a. Dece	edent's Usual Occupation	16b.	American Kind of Business/Industry
215 thin 7; e. an "n Medi	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Given life.	e kind of work done during most of working DO NOT use retired)		
led wi tygien her th		12 years Chil	d Care Provider		rivate
Iryland 21215-0036 should be filed within 72 hours after death with the Marylan of Mental Hygiene. marked other than "natural" or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	Be	Hershel Whitlock	Mary Co		en Surname)
Maryland d 2 should be file th and Mental Hy 7 is marked oth traumatic event	2		ing Address (Street and Number or Rural F		or Town, State, Zip Code)
- C - O L			Hermosa Ave. Balti	more, MD	21214
0 00		T Dulia: 2 Delitation 3 Delitoval form State	osition (Name of Dat ematory or other place)		Location - City or Town, State
Baltimo permit. Pag Department Important: I any Injury o			Memorial Park Jan 2 22. Name and Address of Facility Stew		Landover, MD
Balt permit. Departr Importa any Inji			001 Benning Road, N		
		23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or r	respiratory arrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death) a. Septic Sho	,de		Onset and Death
/Medical Examiner		ue to (or a, a consequence of):	. duchach	u - E	in James
K TOTAL	je l	Sequentially list conditions, if any, leading to immediate b. Sue to (or as a consequence of).	an dystruct		
cuted nd transit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	failure		
58760, ficate be executed physician and s the burial-transit	E	resulting in death) Last Due to (or is a consequence of):	111-0		
68760 fircate be e physician is the buris	edical	d. 1000 4001	_		
I Records, P.O. Box 6 The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 □Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery
at the deat by the att	sicie		Other (specify)		Month Day Year
P.O.		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
Records, P he law requires that has been signed to	d by			1 ☐ Yes	2 No 3 Probably 4 Unknown
aw rec	Completed			24a. Was an	24b. Were autopsy findings available
	mo.			autopsy performed? 1☐ Yes 2 🔯	
VITAL HEC sician: The law certificate has b irector, page 2 s	Be (25. Was case referred to medical examiner?	26. Place of Death (
Or Physical this care and direction	은	1		d. Describe how in	6 Other (Specify)
nding th. : Afte	tion	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	a. Doddibe now in	ary occurred
DIVISION OF all or Attending Phy after death. I Director: After this d in by the funeral d	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	treet, factory, office 28	f. Location (Street City or Town, Sta	and Number or Rural Route Number,
oltal or urs afte					
Division or Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier 1	an occurred at the time, date and place, an nvestigation, in my opinion, death occurred	d due to the cause f at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
To th within To th	Me	29b. Signature and title of certifular	29c. License number		Date signed (Month, Day, Year)
		hu	n D0053219	1.	-19-2008
Q(3)		30. Name and address of person who completed cause of death (Item 23a) (Type Zafar Ansari 7-E Post Office Rd Wa			
S	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	TUOLI, IID 20002		
Regis	trar	JAN 2 3 2008 Beau & Sparks			

death with the Maryland

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hc Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natu any Injury or other traumatic event, the Medical **Physician** /Medical **Examiner** law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, after death Director: Hospital or To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) K. Mc Leys J. mg D50689 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AHILK IN AHA) are MD CENTER 7503 SYRRATTI RD SOUTHERN MARYL HOUS PITAL CLINTUN MD 20931 ND 31. Date filed (Month, Day, Year)
JAN 2 3 2008 State Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

State Registrar 31. Date filed (Month, Day, Year)

JAN 23

Vyron

MO 32 Registrar's Signature Itospital 106 Bow Street

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-00784 State of Maryland / Department of Health and Mental Hygiene Robin Peay Reynolds Certificate of Death 1- For State Reg. No. Registrar 3. Time of Death 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Dav 1807 hrs Reynolds January 28, 2008 Robin Peay Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Clinton Southern Maryland Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number _{Country)} Washington **Funeral** Months Min. 2/29/1960 Days 2 X F 47 577-88-1259 Director М Usual Residence of Decedent 10d. Inside City Limits IOc. City, Town or Location 10a, State 10b. County 1 X Yes 2 No Fort Washington MD Prince George's or 28a-f show items 23a or 28a-f sho ist be notified at once, Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20744 612 Potomac Valley Drive 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Married 1 Never Married 4 \times Divorced If Yes, Give Year 1981-1985Specify: Black ō Yes 2 No specify: Pages I and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", o or other traumatic event, the Medical Examiner in 3 Widowed þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Eagle Van Lines 21215-0036 Receptionist 5+ 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) B1ake Margaret Roscoe Peay Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Fort Washington, MD 20744 Potomac Valley Dr. Baltimore, MD (Father) Roscoe Peay 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State MD Veteran's Cemetery 2/6/2008 Cheltenham, MD Important: injury or oth 4 Donation 5 Other Specify Fort Lincoln Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service Livensee 20722 Brentwood, MD Road **Bladensburg** 3401 nony 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line. Death lediça: a.Atherosclerotic cardiovascular disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Exami Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical X UNPENDED the attending physician ed for use as the burial #25a,PII,27,perME,g876, 2/14/08 TI 23d. Date of delivery Box 68760, IF FEMALE: 23c. If ves, outcome of pregnancy Month Year Day 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth 2 past 12 months? Pregnant at time of death Other (Specify) 5 signed by the atter I be detached for u 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown ģ Chronic alcoholism Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? certificate has page 2 s 2 No ✓ Yes ✓ Yes 2 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Hospital: Other Residence 6 Other: examiner? Nursing Home 5 2 V ER/Outpatient 3 DOA Inpatient 1 Yes No 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) After t 27. Manner of Death Certification: Yes 2 No 1 X Natural 5 Pending Director: hours after death. Investigation 28f. Location (Street and Number or Rural Route Number, City 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be or Town, State) Suicide within 24 hours at To the Funeral I determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Will Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 29, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Ling Li, MD Assistant Medical Examiner

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

31. Date filed (Month, Day Year

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** ALBERTA MAY REITZ rinuary /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner edica Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Numbe **Funeral** 1 ☐ M 2 💢 F 393-20-8007 83 9-27-1924 CANADA **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at X Yes 2 No CHARLES INDIAN HEAD MD. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20640 U.S.A. 7 IRVING PLACE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2♥ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married "natural", or 1 ☐ Yes 2 XNo Specify: Specify: WHITE ρ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 12th other 1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be It of Health and Mental EMILY JANE SMITH DWIGHT EARL BADGLEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) REBECCA SAMMONS-DAUGHTER 7 IRVING PL. INDIAN HEAD, MD. 20640 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Maurial 2 □Cremation 3 □Removal from State 4 □Donation 5 □Other (Specify) ARLINGTON NAT. CEMETERY 2-7-08 ARLINGTON, VA. M00479 21. Signature of uneral Service Licensee RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complications caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Don **Physician** /Medical Due to as a consequence of): HEMOSCL BRYSI **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical use as t IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 2 | Fetal death in the past 12 pronths?
1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has l lirector, page 2 s autopsy performed? res 2 No 1⊟ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA P this 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death.

I Director: A
d in by the fi 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral D completely filled in Eccrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

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FEB

DHMH 17 Rev 1/2001

Pembrouke Sq. uhldorf, MD. 20603

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 0.1 Pay 2008 1853 LAVERNE ROWE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBERLAND ALLEGANY MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Oct 12, 1917 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🙀 F MD Director 220-30-8250 90 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show the Medical Examiner must be notified at 1y Yes 2 No Cumberland MD Allegany Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or 3 USA Funeral I 16123 McMullen Hwy 21502 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ñ No If Yes, Give Year or Dates: 14. Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural", or items 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo þ 3X Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Nurse's Aide Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Christian Mortzfeldt Rosalee (Imes) Mortzfeldt ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) gr.daughte 16123 McMullen Hwy Cumberland MD 21502 Marion Brown 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 1/30/2008 MD 4 □ Donation 5 □ Other (Specify) Cumberland 21. Signature of Funeral Service 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a Sirt1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** WKS au. /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician ar s the burial-t Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live birth 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes မှ 2**X**No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 XNatural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation !niurv 1 ☐ Yes 2 ☐ No 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Hospital

Saltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

4 Homicide

29b. Signature and title of certified

29a. Certifier

(Check only one)

Medical

State Registrar

6 Could not be determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

26 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BUMANUE CALLAH. MD.

31. Date filed (Month, Day, Year) FEB 06 2008

500 NEMOCIAL AVE. Cumberland, MD 21502 gistrar's Signature

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of pe

31. Date filed (Month,

32. Registrar's Signature

Race - American Indian. Black, White, etc. Specify: African American 16b. Kind of Business/Industry Private 20c. Location - City or Town, State Approximate Interval Between Onset and Death 23d. Date of delivery Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) January 20, 2008 Lester Miles, M.D. 1160 Varnum St., NE Washington, DC 20017

 A^M

1:35

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 X Yes 2 □ No

Pennsylvania

State Registrar

32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 2 3 2008

29c. License number

D0026024

			1 - For State Registrar	State of M		Эера	rtment of F	lealth and N	Mental Hyg	iene	108	033
	Physic		1. Decedent's Name (First, Middle Ruth		e; tler				2. Date of Dear Month January		oďš ^{ar}	3. Time of De 5:32 p
	/Medi Examii		4a. Facility Name (If not institution Carroll Hospic	n, give street and number)				Location of Death			y of Death arrol	
	Funeral Director		5. Social Security Number 216-34-5284		ge (In yrs. last bir	rthday) Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 1935	9. Birth Cou	place (State or F ntry) yland
	show sd at	Ž	Usual Residence of Decedent 10a. State 10b. County Maryland Carro	511	10c. City, Tow	n or Lo		Vestminst				10d. Inside City I
	with the M ka or 28a-f t be notifie	Direct	10e. Street and Number 1051 Cherrytown				10f. Zip Code	21158	1	0g. Citizen of		
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?	Ever in U.S.	1	Vas Decedent of H Yes, specify Cuba □ Yes 2 No	ispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Ra	ce - Americk, White,	can Indian, etc. hite
Maryland 21215-0036	within 72 ho ene. than "natul ne Medical	Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4or		(Give life.	ent's Usual Occup kind of work done o OO NOT use retired Tomemaker	during most of worl)	king	16b. Kind of E	lusiness/In	
land 2	ild be filed fental Hygi ked other ic event, tl	To Be Co	17. Father's Name (First, Middle, Robert M.	*				18. Mother's Nam	e (First, Middle, I Mae Woo	Maiden Surna		
	and 2 shou alth and M 27 is mar er traumat	-	19a. Informant's Name/Relationsl Joseph A. Seit		det 19b	. Mailin 051	g Address (Street a	and Number or Ru wn Road,	ral Route Number Westmin	; City or Town	, State Zij MD 21	158°
Baltimore,	Pages 1.8 ment of He ant: If item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)	3 □Removal from State	20b. Place of Sout Carro	Dispos N ^{cren}	sition (Name of natory or other place Crematory	1/19	Date /2008	20c. Location Winf:	- City or To ield,	
Balt	permit. Pages Department of Important: If if any Injury or once.		21. Signature of Funeral Service	Licensee	3		Name and Addres		lyers-Dur Westmins			
	Physician /Medical Examiner	1	23a. Part1 Enter the disease, or shock or heart failure. List Immediate Cause (Final disease or condition resulting in death)	_a. META	d the death. Do note.	<u></u>	CARC	NOM	A	est,		Approximate Interval Between Onset and Dea
760,	certificate be executed ding physician and se as the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of		THECT	NOM	7			7 000 00
.O. Box 687	sath atten for u	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a	2 Fetal death		Ectopic pregnancy Other (specify)				ate of deliver	ery Day Yea
Vital Records, P.	w requires that the deben signed by the should be detached	Completed by Ph	Part II. Other significant condition DIABET			the un	derlying cause give	en in Part I.	1 □ Y€	es 2 10 16	3 ☐ Prot	he cause of deal
al Re	The la ate has page 2	Compl	DE Was asso referred to an display							ned?	prior to co death?	opsy findings ava empletion of caus
Division or Vit	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification: To Be	25. Was case referred to medical examiner? 1	ation of be 28e. Place of injury	iry 28b. T	Time of njury	28c. Injury Work M 1 🗆 \	er: 4 Nursing Ho	ome 5 Reside 28d. Describe ho 28f. Location (Str. City or Town	nce 6 Poti	red	
	e Hospita 124 hours e Funeral letely filled	Medical Ce	29a. Certifier 1 ☐ Certifyin (Check only one) 2 ☐ Medical I	g Physician: To the best Examiner: On the basis o and manner sta	f examination and	, death d/or inv	occurred at the time estigation, in my of	ne, date and place, pinion, death occur	and due to the carred at the time, d	ause(s) and mate and place,	anner as s and due to	tated. o the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	1 . /	T-00 0.4		29c. License	number	29	9d. Date signe	d (Month,	Day, Year)

e contribute to the cause of death? ⊮ô 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 1∐ Yes

25. Was case refer examiner?	red to medical			26. Place of Dea	ath (Check only one)
1 ☐ Yes 2 ☐	100	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 [OCA Other: 4 Nursing H	
27. Manner of Deating 1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		ome, farm, street, factorify)	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier	1 Certifying Ph	ysician: To the best of my kn	owledge, death occurre	ed at the time, date and place	e, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Year)

03316 3. Time of Death

5:32 p

9. Birthplace (State or Foreign Country) Maryland

10d. Inside City Limits 1 XYes 2 No

Approximate Interval Between Onset and Death

m onthe

BOW IN

Year

30. Name and address of person who completed cause of death (1)em 23a) (Type, Print)

AITRACITEDU 700 A

32. Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year)

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Amended Items 7 & 8 per F.D. 01/28/2008 Carroll County Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Yeer **Physician** 10:30 p 2008 January 16 Naomi Louise Sirkis /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Ctr Examiner Carroll Lutheran Village Health Care Carroll Westminster If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) July 1 126 Year 927 **Funeral** Hours Days 1 M 2 ST 80 MD Director 214-26-0621 Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County If item 27 is marked other then "natural", or items 23s or 28s-1 show or other traumatic event, the Medical Examinar must be multiled at ty Yes 2 □ No Carroll Westminster MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 205 St. Mark Way Apt #500 21158 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Yo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Yeo Specify: If Yes, Give Year or Dates: Specify: White à 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7; Depertment of Health end Mentel Hygiene. Important: If item 27 is marked other then "na eny injury or other traumatic event, the Media 2006. Elementary/Secondary (0-12) College (1-4or 5+) Medical Registered Nurse 5+ 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Emma Estella Myers ပ Walter Harrison Bowers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3430 Augusta Road Manchester, MD Sue Bolander/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Slate 20a. Method of Disposition Burial 2 Cremation 3 Removal from State St. Mary's Cemetery 1/26/2008 Silver Run, MD 4 □Donation 5 □ Other (Specify) Printer Algerady Home and Chapel, P.A. 21. Signature of Funeral Service Licensee 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bilderal **Physician** numone /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy hes certificate 1 Yes 2 No Coronar filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA မ this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendiwithin 24 hours after death.
To the Funeral Director; A completely filled in by the fu М 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check onl one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00050763 10+5 30. Name and address of person who completed cause of death (Item 26a) (Type, Print) Westmente MD 21158 St. Lula cercle 200 ERNESTO MEMODIA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		For State		State of M	laryland		artment of H			lental Hy	/giene	e	0	00010
	-	Registrar 1. Decedent's Nam	e (First Middle 1	aet)		Cer	tificate of	Deat	rh	2 Data of D	Reg. No	200	8	03310
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and and		Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Loc	cation						100	I. Inside City Limits
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leath with ns 23a o must be		612 N.	2nd Stre	et			19940)			US	Δ		
filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral	11. Marital Status		12. Was Decedent Armed Forces	Ever in U.S	S. 13. V	Vas Decedent of H	ispanic (Origin? (Spe	ecify Yes or N		14. Race - Ar Black, W		
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ages nt of h if ite			☐Cremation 3 ☐	Removal from State	200. Pi	emetery, crem	sition (Name of natory or other place	e)) 	Date	20c. L	ocation - City	or Towi	n, State
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural"; any injury or other traumatic event, the Medical Exalone.		4 ☐ Donation 21 Signature of Fu	5 Other (Special Service Lice		_ Bla		emetery . Name and Addres	es of Ear	1/25	/08	Bl	ades, 1	DE	
Department of the second of th		Paind	an in		FSP	F	followay 001 Snow	Fune	eral H	ome Pr Salis	ofes bury	sional	Ass 1804	sociation
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eath certifi attending p for use as	Physician/Me	23b. Was decedent in the past 12		23c. If yes, outcome 1☐Live birth	2 🗆 Fetal	death 3 🗌	Ectopic pregnancy					23d. Date of o	delivery Da	ay Year
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or Attending Praffer death. Director: After the in by the funeral	ü	 Manner of Death Manner of Death 	5 Pending	28a. Date of Inju (Month, Da		28b. Time of Injury	28c. Injury Work			28d. Describe	how inju	ry occurred		
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		1- For State Registrar				ertificate o	f Health and M f Death			ı. No. 20	3. Time of Death
Physic dical Exan		1. Decedent's Name (F		ilvers	toin C	vruc		1		Day Year 2008	0025 hrs
		4a. Facility Name (if no					4b. City, Town, or Loca		oundary 2.	4c. County of D	
		822 Fair Oaks			T		Hyattsville		0 D 1 (D)	Prince Geo	orge's Birthplace (State or
Funera Directo		5. Social Security Num		S. Sex		s. last birthday) Yrs	Months Days I	f Under 24Hrs. Hours Min.			oreign Country) N.C.
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72 hou n "nat	eted	Elementary/Second			(1-4 or 5+)	during n	nost of working life. DO	NOT use retire			
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f show any inner or other tranmatic event, the Medical Examiner must be notified at once.			Cremation Other Spe	cify:	I from State	t Linco	ther place) oln Cem. Name and Address of P Hackett's	Facility Funer	al Cha	apel, In	
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State 31. Date filed (Month, Day, Year) jistrar JAN 3.1 2008 DHMH 17 Rev 1/2001 OCME 2006

Registrar

32. Registrar's Signature ORIGINAL

Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Ilygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Nederle Examiner must be notified at once.	Funeral Director	20 Mour	nt St						219		.0./ 5===:6	. Vee or No		J.S.A	encan Indian, Black,
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Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a Certifier		g Physician	: To the best of	f my knowled	do do	ath occurred at	the time	e, date and c	olace, and d	ue to the car	use(s) a	nd manner as	stated.
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	Ž	29b. Signature a	ind title of ce	rtifier M.	08 11	LD		1		.C.M.E.				nuary 30, 2	
		30. Name and a	ddress of no	son who cor			m 23a)								
		Tasha Gr			sistant Me			111 Penr	n Stre	et, Baltim	nore, MD	21201			
	tate				23	istrar's Signa	ture	7-10							
Regist	tra	1	FEB 0	5 211	X	A A	-	JUST OF	-						

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			For State Registrar	State o	f Marylan	•	artment of rtificate o		and M		jiene	008	033	21
			1. Decedent's Name (First, Middle,	Last)						2. Date of Dea Month	th Day	Year	3. Time of	Death
	Physici /Medic		Lovely P.	Tay	lor					January			6:45	a ^M
	Examin		4a. Facility Name (If not institution, g	give street and nu	mber)		4b. City, Town	, or Location o	of Death		4c. C	ounty of Dea	th	
			Genesis Health/					er Spri		0 D : (D:)		ontgom		
	Funeral		,	5.Sex 1 ☐ M 212 F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Ye Months Day		Min.	8. Date of Birth (Month, Day	Year)	Co	thplace (State o	-
	Director		249-34-3728 Usual Residence of Decedent	111	95					April 2	5, 1	914 5	outh Ca	rollii
	/land		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside C	
	filed within 72 hours after death with the Maryland Hygiane. Ither than "natural", or items 23a or 28a-f show ant, it a Medical Examinar misal ba notified	tor	Maryland Prince	George'	s Mi	tche11	ville						1 k□ Yes	2 🗌 No
	or 284	Funeral Director	10e. Street and Number				10f. Zip Cod	9			10g. Citize	n of What Co	ountry?	
	th wil	aic	11411 Lake Arbo	r Way			2072	1				ted St		
	r dea	ner	11. Marital Status	Armed Fo		.S. 13.	Was Decedent of If Yes, specify C	of Hispanic Origination	gin? (Spe n, Puerto I	cify Yes or No- Rican, etc.)	14	. Race - Ame Black, Whit	erican Indian, le, etc.	
3	or th	by Fu	1 Never Married 2 Marned 3 Widowed 4 Divorced	If Yes, Gi	ve		1□ Yes 2⊡xi	No Specify:			s	pecify:		
5	hours fural	d b	15. Decedent's	Year or D	ates:	16a Dece	dent's Usual Oc	cupation			16h Kind	N of Business	egro	
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4	the the	E O	Elementary/Secondary (0-12)	College (Р	ara Pro	fession	าล1		Gov	ernmen	t	
3	Hyg other	0	17. Father's Name (First, Middle, La		<u> </u>		ara rro			(First, Middle,				
<u> </u>	ld be lental kad ic ev	To B	John Shelton					Н	latti	e Byrd				
7	s 1 and 2 should be filed within 72 hours after death with the Maryla ff Health and Mental Hygians the files of 1 is marked other than "natural", or frame 23a or 28a-1 ehou other treumatic evant, in a Medical Examinar mission notified at	-	19a. Informant's Name/Relationship	p (Type, Print)		19b. Maili	ng Address (Str	et and Numbe	or Rura	l Route Numbe	r, City or	Town, State,	Zip Code)	
Ě	alth a		Cheryl Y. Taylo	r - Daug	hter	1141	l Lake	Arbor W	lay M	itchell	ville	e, MD_	20721	
ני ב	tan Itam otho		20a. Method of Disposition		20b. F	lace of Dispo	sition (Name of	place)	D	ate	20c. Loca	ation - City or	Town, State	
	Pege not c not: H iry or		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				oln Cem		an 2	2, 2008	Bre	entwoo	d, MD	
	permit. Peges 1 and 2 should be filed within 72 hours postment of Health and Mental Higgane. Important: If Item 27 is marked other than "natural", any injury or other treumatic event, it a Medical Exa pnce.		21. Signature of Funeral Service Li	censee	2hm	/ W1	2. Name and Ad		-					
ם	88 5 8		Mhari	·NO	alle		4001 Ber	nning R	load,	NE Was	hing	ton, D	C 20019	
			23a. Part . Enter the disease, or or shock or heart failure. List or	omplications that only one cause on	caused the deat each line.	h. Do not en	er the mode of	tying, such as	cardiac o	r respiratory ar	rest,		Approximat Interval Bet	ween
F	Physician		Immediate Cause (Final disease or condition	_a. Sep	cic								Onset and	Jeath
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	D 15	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	uence of):								
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₹	w requires that the death certifics been signed by the attending ph should be detached for use as t	Physician/Med	IF FEMALE:	23c. If yes, ou	tcome of pregna	ancy					23	d. Date of de	livery	
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<u>.</u>	that ned b deta	by Pt	Part II. Other significant condition	s contributing to c	leath but not res	ulting in the u	nderlying cause	given in Part I.		23e. Did to	bacco us	e contribute t	o the cause of	leath?
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9	Physicien: The law requires that the death certificate this certificate has been signed by the attending physical director, page 2 should be detached for use as the	0	25. Was case referred to medical					26. Place	of Death	(Check only o				
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2	ing Ph terth heral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date	of Injury oth, Day Year)	28b. Time o	f 28c. I	njury at Work?		28d. Describe h	now injury	occurred		
2	endir seth. or: Af	atic	2 Accident investiga	ation		. ,		I∐Yes 2□	No					
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	Hosp 24 hou Fune Fune tely fii	cai	(Check only 2 Medical E	Physician: To the xaminer: On the b	pasis of examina									s)
	To the Hospital or Attending I within 24 hours after deeth. To the Funeral Director: After completely filled in by the funer	Medical	29b. Signature and title of certifier	and mar	nner stated.		29c Lie	ense number			29d. Date	signed (Mor	th, Day, Year)	
	8 18 1		255. Oignature and this or certifier	WILLIAM	MA	M.D	4							8
^	(3)		20 Name and address of	MONI!	on of days (to	225) (7		064208			Jai	iuary	10, 200	
2	(5)		30. Name and address of person w Saadia Husaui		-			ing, MD	209	06				
	Sta	ite						J,						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day 17, Queen Thompson 2008 16:30 P^M January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√2 F 67 Director 225-52-8621 April 30,1940 Blackstone, VA Usual Residence of Decedent 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits Director MD Prince Georges Suitalnd 1√2 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3332 Curtis Dr. #103 20746 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Black ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Nightclub Owner Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Thompson Martha Giles ္က 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Outten/ Husband 3332 Curtis Dr. #103, Suitland, MD 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Riverdale Park Crem. Riverdale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 28 22. Name and Address of Facility Johnson & Jenkins Funeral Home 21. Signature of Funeral Service Licens 716 Kennedy St. NW, Washington, DC 20011 23a. Pal 1. Enter the disease, or convication, that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one called on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Anoxic /Medical Due to (or as a consequence of): Examiner Air Way Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed ASPIRATION SEPSIC Preymonia burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Yea Day 4□Pregnant at time of death 5 Other (specify) 9 ☐ Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4x Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 autopsy performed? 1∐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🔽 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending (Month, Day Year) 1 X Natural 5 Pending n 24 hours after death.

ne Funeral Director: A pletely filled in by the fi investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Function (Check only and manner stated. To the I within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D0065729 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Farzad Malekanian, M.D. 7503 Surratts Rd., Clinton, MD 20735 31. Date filed (Month, Day, Year, 32. Registrar's Signat State 2008 JAN 23 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 945 AM M Month **Physician** Year DI /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner Anne Arundel 117 Edgemere Drive Annapolis 8. Date of Birth (Month, Day, Year) June 27, 1 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days **X** M 2□ F Yrs 1957 Director 50 220-66-7035 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a State 10c. City, Town or Location 10d. Inside City Limits 10h County r 28a-f show notified at 1 ☐ Yes 🏋 No Director Maryland Anne Arundel **Annapolis** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be United States 21403 117 Edgemere Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 ☐ Never Married 🏋 Married 1 ☐ Yes **2 TV**No If Yes, Give X Year or Dates: 1 ☐ Yes XX No Specify Specify: White ģ 3 Widowed 4 Divorced Completed ih and Mental Hygiene. 7 is marked other than "natui traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dispatcher / Field Supervisor Excavating Company 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Lynn Edinger Minard Evans Tupper 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Nina Jean Tupper / Wife 117 Edgemere Drive Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 nent of H ant: If ite Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department of Important: If any injury or once. Hillcrest Mem. Gardens 1/25/2008 Annapolis, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral/Service Lic 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the stase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours at er death To the Funeral Director; 6 ☐ Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of gerifier 29d. Date signed (Month, Day, Year)

State Registrar JAN 2 2

2008

3altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

and death (Item 23a) (Type, Print)

ANNAPOUS ON COLOGY CONTR 900 BUSTO AFRO SUITES OF ANNAPOUS, MD 2149

ANNAPOUS, MD 2149

			For	State of Mary	•			Mental Hy	/giene			
			1 - State Registrar Certificate of Death Reg. No. 2008							03324		
	Physici	ian	1. Decedent's Name (First, Middle, Last)					2. Date of D Month	2. Date of Death Month Day Year 3. Time of Death			
33	/Medi	cal	JAN 21, 2008								1:35 AM	
	Examir	ner	4a. Facility Name (If not institution, give				n, or Location of Deat Tルの足匠	ırı	4c. C	ounty of Death		
	Funeral		5. Social Security Number 6.3		n yrs. last birthday)	If Under 1 Ye	ear If Under 24 Hrs	8. Date of Bi	Birth 9. Birthplace (State or Foreign Country)			
Ь	Director			ПМ 21ХГ	58 Yrs. Months Day		ys Hours Min			9, 1949 Virginia		
, L	ours after death with the Maryland ral", or Items 23a or 28a-f show Examiner must be notified at	_	Usual Residence of Decedent					7 0 0 2 2 7				
			10a. State 10b. County	10	c. City, Town or Lo	ocation				1	0d. Inside City Limits	
		Director	Maryland Cecil		North I						1 ☐ Yes 🏋 No	
		Dir	10e. Street and Number	10f. Zip Coo				en of What Cour				
		Funeral	324 Old Bayview	12. Was Decedent Eve	rin IIS 13	2190		Pagifu Vac or N		ed Stat		
		Ē	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	1 ☐ Yes 2 💢 No		Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et		Black, White, etc. Specify: White			
336		þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ▼ No Specify:						
215-0036		Completed	15. Decedent's E (Specify only highest gro	ucation 16a. Dece		dent's Usual Occupation			16b. Kind of Business/Industry			
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and	permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturally injury or other traumatic event, the Me Hoal once.	Be	17. Father's Name (First, Middle, Last					me (First, Middle		,		
<u> </u>		은	Edward Eugene Moore, Sr. Maude Letitia Parris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, Goldon Skayip Appartments									
Maryland			Ronald L. Truslo	**							yland 21921	
ē,		1	20a. Method of Disposition		20b. Place of Dispo		· .	Date		ation - City or To		
JO.			1 ☐ Burial 2 【Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci.	JRemoval from State	cemetery, cred Mayerdale		1	uary 2008	Novan	k, Dela	17.12.12.0 17.12.12.0	
Baltimore,			21. Signature of Faneral Service Lice				dress of Facility C	rouch Fi	uneral	Home	iwale	
ä			Melly Ca								yland 21901	
			23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between									
	Physician /Medical Examiner		Immediate Cause (Final							Onset and Death		
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68760,	e be e siciar s buri	cal		_ d								
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit											
		J/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 3 ☐Ectopic pregnancy				23	23d. Date of delivery			
Θ.		sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown	4□Pregnant at tim	Other (specify				Month Day Year			
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360		혍	PLEURAL EFFUSION					auto	24a. Was an autopsy findings available prior to completion of cause of death?			
a								1□ Yes	2 X No	1 ☐ Yes	2 □ No	
or Vital Records,		Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 (X)No	Hospital:	0.T.ED/Ot*	4 05 804	Other:	ath (Check only				
Division or		.: To	27. Manner of Death	28a. Date of Injury	2 ER/Outpatier	K 3 DOA	4 □ Nursing I njury at Nork?		me 5 ☐ Residence 6 ☐ 28d. Describe how injury of			
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	the I		one) and manner stated.									
	To wit		29b. Signature and title of certifier			29c. License number			29d. Date signed (Month, Day, Year)			
•	6		pluza H. W.	LOETING	- Marin 20 1 77		063327	<u> </u>	Jan	21,2	28	
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GIZAW WUNDETHWIT, MI) 2434 WEST BELVERERE AVE, BITCTIMURE, MID 21215									
	Sta	ite	31. Date filed (Month, Day, Year)	32, Registrar's	Signature						ZIXIS	
	Registr		IAN 2.3 20	INS Res	Al An	call 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** D'S Month 9 /Medical 4a Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner ICOMICO alis bu Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. Date of Birth (Month, Day, Year) 5/24/1932 **Funeral** Months 1 M 2 F Days Hours Min 214-28-378 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside Offy Limits ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No **Funeral Director** Mr omoke 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or iten any injury or other traumatic event the Mariana. Black, White, etc. 2 No 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☑ Divorced Baltimore, Maryfánd 21215-003 Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) played 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margare ပ Jane 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) tocomoke Denise MD 21851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State salishary Abilla 4 ☐ Donation 5 ☐ Other (Specify) Wary land 21. Si nature of Funeral Service License 22. Name and Address MO 21801 Soilisbary Benie Snith 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HRPATO CRULL **Physician** /Medical Due to (or as a consequence of): Examiner ARCINOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, aftending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 🔲 Yes Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ ₩o 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2[7] No 1 ☐ Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Accident within 24 hours after des To the Funeral Directo completely filled in by th 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of cortifler 29d. Date signed (Month, Day, Year) 00058410

OMP

State Registrar 31. Date filed (Month, Day, Year) JAN 23 200

6 Hungu

WARY COASTAL

32. Fegistrar's Signatur

3 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSPICK

P.O BOX 1732 SArismonyuno 21802

Physician

/Medical

10a. State

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Examiner

Funeral

Director

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"natural", or items 23a or edical Examiner must be r

Directo

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Maryland 21215-0036

ULRICH Baltimore,

Division or Vital Records, P.O. Box 68760

	resulting in death)	a. 101 - 207 - 51 - 51	ccol con and)· ~ (car > ,
		Due to (or as a consequence of):		
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dical Exar	that initiated events resulting in death) Last	c Due to (or as a consequence of):		
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		23d. Date of delivery Month Day Year
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Complet		, , , , , , , , , , , , , , , , , , ,		topsy prior to completion of cause of death?
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P	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 Nursing Home 5 Re	sidence 6 Other (Specify)
	27. Manner of Death All Alatural 5 Pending 2 Accident investigation	n M	Injury at Work? 28d. Describe	e how injury occurred
Medical Certification:	3 ☐ Suicide 6 ☐ Could not be determined			(Street and Number or Rural Route Number, own, State)
edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best of my knowledge, death occurred at niner: On the basis of examination and/or investigation, in and manner stated.	he time, date and place, and due to the my opinion, death occurred at the time	ne cause(s) and manner as stated. e, date and place, and due to the cause(s)
-	29b. Signature and title of certifier	290 1	cense number	29d. Date signed (Month, Day, Year)

State Registrar

within 24 hours after dear

of person who completed cause of death (Item 23a) (Type, Print)

Year) 2 3

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1/21/08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 0

		1 - State Registrar Certificate 1. Decedent's Name (First, Middle, Last)	e of Death		2 0 0 0 g. No.	U J J L I
Physic		Beatrice Lewis Wright		2. Date of Death Month January	Day Year 14, 2008	3. Time of Death 12:58 P M
/Medi Examii			Town, or Location of Death	January	4c. County of Death	
			Washington		Prince Geo	rge's
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under		8. Date of Birth (Month, Day,	9 Birthr	place (State or Foreign
Director		489-22-4301 88 Yrs.	Days Hours Will.	Feb 26	1919 Tenne	* *
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faryla sho	5	MD Suitland				1X Yes 2 □ No
the N 28a-f	Director	Prince George's 10e. Street and Number 10f. Zip	Codo	100	g. Citizen of What Cour	atry?
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permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic even once.		20a Method of Disposition 20b. Place of Disposition (Nam	ne of	Date 20	Oc. Location - City or To	
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artm oortar injur			d Address of Facility	D 4		
any any	0.0	Mensy Marks 5538	d Address of Facility nder S. Pope Mariboro Pik	ė/Forestv	ville, Md.	20747
Physician /Medical Examiner		23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	e of dying, such as cardiac			Approximate Interval Between Onset and Death
rtificate be executed ng physician and as the burial-transit	al Examiner	Sequentially list conditions, it by the sequence of the sequen				
eath ce attendii for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 20 No 9 Unknown Unknown			23d. Date of delive	ery Day Year
v requires that the d been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the underlying ca	use given in Part I.		acco use contribute to t	,
law requires t as been signe 2 should be c	Completed			24a. Was an	24b. Were auto	ppsy findings available
The lav	E O			autopsy performe 1 Yes 2	ed? death? ☑ No 1 ☐ Yes	mpletion of cause of 2X No
ian: rtifica stor, p	Be C	25. Was case referred to medical	26. Place of Deat	h (Check only one)		
nysici nis ce direc	.0	examiner? 1 Yes 254.No Hospital: 1 Inpatient 2 ER/Outpatient 3 DO/	A Other: 4 Nursing Ho	me 5 Residen	ice 6 Other (Specia	W RESIDE O
the Hospital or Attending Physician: hin 24 hours after deart. the Funeral Director: After this certifical impletely filled in by the funeral director,	Certification: T	2 Accident investigation M	Bc. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	v injury occurred	
ital or A	Certifi	4 Homicide determined building, etc. (Specify)		City or Town,		
the Hosp in 24 hou the Funer pletely fil	cal	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, death occurred a 2 ★ Medical Examiner: On the basis of examination and/or investigation, and manner stated.	in my opinion, death occur	red at the time dat	te and place, and due t	o the cause(s)
To the within 2 To the comple	Σ	29b. Signature and title of certifier	License number	290	d. Date signed (Month,	Day, Year)
	3	m 8i)	1) X 2 3 9 7		10-08	
2 (10)		and manner stated. 29b. Signature and title of certifier 29c. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Carlot Carlot (Ving 4)	and Hol:	fort o	Arhita	19 63 H

State Registrar



Medical Certification: To Be Completed by Physician/Medical Examiner

Please 1			delible Ink. Ensure A	-		02228
For State Registrar	State of Maryla		artment of Health and I <i>rtificate of Death</i>	, ,	eg. No.	03328
Decedent's Name (First, Middle, Las				2. Date of Deat Month	h Day Year	3. Time of Death
RUTH ELEANORA WOO 4a. Facility Name (If not institution, give			4b. City, Town, or Location of Deatl	01	16 2008 4c. County of Dea	2:40 P M
4a. Facility Name (If not institution, give PRINCE GEORGES HOS	SPITAL		CHEVERLY		PRINCE GI	
5. Social Security Number 578–26–9181 6. Sec. 11		yrs. last birthday) 91 Yrs.	if Under 1 Year If Under 24 Hrs. Months Days Hours Min.		Year) C	thplace (State or Foreign ountry)
10a. State 10b. County MD PRINCE 0		City, Town or Lo	Decation HEIGHTS			10d. Inside City Limits 1√ Yes 2 No
10e. Street and Number			10f. Zip Code	1	0g. Citizen of What C	ountry?
1113 BOOTH LANE			20743		ISA	
11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (S if Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☐ No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whi	te, etc.
15. Decedent's Ed (Specify only highest grad		16a. Dece	dent's Usual Occupation	rkina	16b. Kind of Business	/Industry
Elementary/Secondary (0-12) 12TH	College (1-4or 5+)	`life.	DO NOT use retired) EMAKER		PRIVATE	
17. Father's Name (First, Middle, Last)	·		18. Mother's Nar	me (First, Middle, I	Maiden Surname)	
CHARLES FORD				TH SMITH		
19a. Informant's Name/Relationship (7 JANICE JACKSON/DAT	• •		ng Address (Street and Number or Ri 69TH PLACE HYATTS			Zip Code)
20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	cemetery, cre		22/2008 B	RENTWOOD,	MD
21. Signature of Funeral Service Licen	see the see that the see that the see	I _	2. Name and Address of Facility J. F			
23a. Part I Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that caused the done cause on each line.	eath. Do not en	_			Approximate interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a constitution of the constit	IN A sequence of):	LEFF E DISO	NDER	2	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. if yes, outcome pf pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	blivery Day Year
Part II. Other significant conditions of	ontributing to death but not	resulting in the u	underlying cause given in Part I.	23e. Did to	_	to the cause of death? Probably 4 Unknown
				24a. Was a autops perfor 1 Yes	sy prior to	
25. Was case referred to medical examiner?	Hospital:	•	Other:	ath (Check only or		
1 Yes 2	28a. Date of injury (Month, Day Yea	2 ER/Outpatie 28b. Time of Injury	THE SELECT 4 NUISING P		ence 6 □Other (Sp ow injury occurred	ecify)
2 Accident investigation 3 Suicide 6 Could not be determined		At home, farm, st ecify)		28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
			th occurred at the time, date and place nvestigation, in my opinion, death occ			
29b. Signature and title of certifier	> $<$		29c. License number 58/ 8	2	29d. Date signed (Mor	nth, Day, Year) 5 - 2008
30. Name and address of person who concern the control of the cont	•		, Print) WAY CENTER DRIVE	# 113 GR	EENBELT,MA	RYLAND 20770

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JAN 2 2 2008

32. Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** CASBOURNE WEST 1453 P ALD JANUARY 2006 20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMOREC THE JOHNS HOPKINS HOSPITAL LLX If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 3, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**%** M 2 □ F 70 110-30-0878 Ohio Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Directo Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20902 USA 10104 Gladstone Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1%]Yes 2□No If Yes, Give Year or Dates: Vietnam 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 21X No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Scientific Equipment Sales & Marketing Manager 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Delphia Lintala Charles West ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10104 Gladstone Street, Silver Spring, MD 20902 Evelyn Jean West/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 22, 1 ☐ Buriat 2 【Cremation 3 ☐ Removal from State Jan. 4 ☐ Donation 5 ☐ Other (Specify) 2008 Metropolitan_Crematory Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. Silver Spring, MD 20901 500 University Blvd, W,. 23a. Part1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANOXIC BRAIN INJURY **Physician** MASSINE 4 DAYS /Medical Due to (or as a consequence of): **Examiner** HEMOP TYSI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner il or Attending Physician: The law requires that the death certificate be executed after death.

Director; After this certificate has been signed by the attending physician and ESOPHAGEAL Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To illed in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours at To the Funeral D Hospital 29a. Certifier 🕍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert MD 20,200% 211 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THE JOHNS HOPKINS HOSPITAL 600 N. WOLFE ST BALTIMORE MD Z1287 TREYOR ELLISON 31. Date filed (Month, Day, Year) 3 Registrar's Signature State **JAN 23** 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? | | | | | | Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** 1/18/2008 7:00pM Bula May Wonch /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Gambrills Anne Arundel 2261 Mistwood Circle If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 K F 82 Director 578-30-9837 12/23/1925 NY Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Gambrills 10b. County rral", or items 23a or 28a-f show I Examiner must be notified at Anne Arundel 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2261 Mistwood Circle 21054 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. iled within 72 hours after 1 Never Married 2 Married Specify: White altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 11 Homemaker other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I int: If item 27 is marked of Alma Seward James Jones ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pasadena, MD 21122 304 Christy Rd. Kenneth Wonch 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages I Department of H Important: If ite any injury or ot ₩₩Burial 2 Cremation 3 Removal from State Maryland Veteran Cem 1/22/2008 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licenses Annapolis, MD 21401 aly 12 Ridgely Ave. 23a. Part1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Approximate Interval Between Onset and Death elevor Cardio Vasculas Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of, Examine The law requires that the death certificate be executed that initiated events resulting in death) Last the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl for use as t 23c. If ves, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? 1☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 1 Natural 2 □ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide

or Attending Physician: after death within 24 hours completely

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and title

29d. Date signed (Month, Day, Year)

Name and ad 80FE

Christopher Deborja

State Registrar

31. Date filed (Month, Day, **JAN 2 2**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2008 3:00 Olivia Williams Januar Irene /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner Plata La Civista Medica 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 1 □ M 2 X F 11/22/1916 218-38-5068 Maryland Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygtene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at once. 1X Yes 2 No Director Charles LaPlata Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 11615 Charles Street USA 20646 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 Specify Specify: Black þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Johnson Olivia ပ Phillip Coates 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11615 Charles St. LaPlata, Maryland 20646
ace of Disposition (Name of Date 20c. Location - City or Town, State Anna Briscoe/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Mary's 1/25/08 Bryantown, Maryland 21. Signatur of Funer Viervice Limitse. 22. Name and Address of Facility Adams Funeral Home PA 20605 Aquasco Rd. Aquasco, Maryland20608 191 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List gyly one rause on each line. Immediate Cause (Final disease or condition resulting in death) NENHONICA **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 212 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO Hospital: Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar DHMH 17 Rev 1/2001 Medical Center

7C Post Office Rd. Waldorf MD 20602

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

enna

2008

Song Chon MP, 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician MARY LOUISE WATTS JANUARY 29 2008 8:44 /Medical 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital Elkton Cecil If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, June 14 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** ^{Year)} 1933 Days 1 ☐ M 2 🖫 F 74 213-30-3661 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. inside City Limits 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 XYes 2 □ No MD Director Cecil Elkton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 27 Willow Court 21921 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11. Marital Status Black, White, etc. 1 □ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐XNo Black Specify: þ 3 ☐ Widowed 4 X Divorced Completed 16h Kind of Business/Industry th and Mental Hygiene. 7 Is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 3 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Preston Turner Elsie Viola Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tragence. Barbara Willingham (daughter) P.O. Box 5507 Newark, DE. 19714 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Pisgah Cemetery 2/2/08 21. Signature on Juneral Service Lice Galena Funeral Home of Stephen L. Sc. 118 West Cross St. Galena, MD. 21635 M00510 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. immediate Cause inal disease or condition resulting in death) Acute Physician hows /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 □Unknown 23e. Did tobacco use contribute to the cause of death? Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 9 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 25. W case ferred to medical examiner? autopsy perform 2 No 2 No VESCH 1 ☐Yes Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Hospital: 2 ER/Outpatient 3 DOA P 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3☐ Suicide determined

the Hospital or Attending Physician; The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, I Director: After to in by the funeral within 24 hours a To the Funeral I

Baltimore, Maryland 21215-0036

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certified

Gorez MO 29c. License number 65902

Elkton

29d. Date signed (Month, Day, Year) 0 %

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (athedral Street 3 8

32. Restar's Signature 31. Date filed (Month, Day, Year) FEB 06 2008

Medical

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Helen R. Brown Feb 2008 12:15a M 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Hospital Belair Harford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Maryland 6. Sex 7. Age (In vrs. last birthdav) 8. Date of Birth **Funeral** Feb21, 1915 Months Days Hours 1 □ M 2 □ XF 92 219-66-5202 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f shov ner must be notified at MD Harford Director 1 ☐ Yes 2 ☑ No Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 519 Anchor Drive 21085 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Be Completed by Specify: White 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) the Homemaker 11th own home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental James E. Gallup Lena R 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a :: If Item 27 Is r or other tran James Brown /grandson 519 Anchor Drive Joppa MD 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Cemetery 2/8/08 4 □ Donation 5 □ Other (Specify) Baltimore MD 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature y Fund al Service Licenses Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or count shock, or heart failure. List only or lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** the memore /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): use as the burial-transit Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) should be detached 9□Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No after death 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 03227 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Dunn

31. Date filed (Month, Day, Year)

615

DHMH 17 Rev 1/2001

Suite 106 Bel

W. MacPhail Rd

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician 10:50 PM 2008 Februar 03 /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Battimore (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. | Date of Birth (Month, Day, 9. Birthplace (State or Foreign Funeral Days Months Year 4 Carolina Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 res 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14. Race - American Indian, . Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ò 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired)

Domestic Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be UNKnown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sloan 20b. Place of Disposition (Name of 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Solvice Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Phenoca /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate caus. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last 1 e ren Due to (or as a consequence of): Examiner The law requires that the death certificate be executed bunal-transit Diabetes

Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: ase 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy for Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be lirector, page 2 s autopsy perform 2XNo 1 ☐ Yes 2 🗆 No or Attending Physician: irs after death.

Jeral Director: After this certifical filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient ဥ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 ☐ Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral C completely filled i To the Hospital 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Alchewh 24389 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Alcheich

2008

31. Date filed (Month, Day, Year)

FEB

32 Registrar's Signature

Division or Vital Records, P.O. Box 68760,

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		For State		State of I	Marylan	-	artment of F		Mental Hy	giene		
		1 - State Registrar 1. Decedent's Nam	ne (First. Middle. L	ast)		Cei	rtificate of	Death	2. Date of De	Reg. No.	008	3 Time of Beath
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Examin			_	ve street and number	er)			r Location of Deat		4c. Coun	ty of Death	•
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Funeral Director		214-18-2		1 M 2 X F	88 Age (III yis.		Months Days	Hours Min.		3 1919	9. Birth Cou Mar	place (State or Foreign intry) yland
put »		Usual Residence of 10a. State	f Decedent 10b. County		10c Cit	y, Town or Lo	cation					10d. Inside City Limits
should be filed within 72 hours after death with the Maryland mod Mental Hygiene. In a further a first of the filed within "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	tor	MD	Balti	more		atonsvi						1 ☐Yes 2 No
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permit. Pages I and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.			☐ Cremation 3 [5 ☐ Other (Spec	□Removal from Sta ify)	te	od Shep	her Cem.	2/9	/2008	Elicot	tt Ci	ty, MD
ermit. Departi n porti ny Inj		21. Signature of Fu	uneral Service Lice Steven	ensee ✓ H. Ŵilla	ams	22	Name and Addre	ss of Facility	Home, P.	Α.		
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To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical	29a. Certifier (Check only one)	1 Certifying P 2 Medical Exa	hysician: To the be miner: On the basis and manner	of examina	wledge, death ition and/or inv	occurred at the tire vestigation, in my o	me, date and plac opinion, death occ	e, and due to the urred at the time	cause(s) and r , date and place	nanner as s e, and due i	stated. to the cause(s)
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Me		of certifier	1 -			29c. Licens	e number		29d. Date sign	ed (Month,	Day, Year)
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		30 Name and addr	ress of person who	completed cause o	f death (Item	123a) (Type, I	Print)	urm f	0	N - A		201229
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Sandra Cudd 12:45P™ 2008 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 10, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1952 Days Hours Months Mary Land 1 □ M 2 🗓 F 55 214-60-2098 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8023 Paul Martin Drive 21075 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: Specify: White 3 ☐ Widowed 4X Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josh T. Johns Francis Redmiles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a:
Important: If item 27 is
any Injury or other trau 737 Lake Road Bozrah, CT 06334 Chanda Curtis, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 02/05/08 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Gregor

Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** years concer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transit Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 □ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Sother (Specify) CSO (Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural
2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Hospital

29b. Signature and title of certifier

29a. Certifier (Check only one)

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMEN J. CHAMES WW 6701 N-Chambes ST RW SON MO

State Registrar 31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2008 Year **Physician** 6, 2:40 PM Kenneth R. Clark February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday **Funeral** Months 1 M 2 □ F 69 Director 266-56-0956 Dec 1, 1938 Michigan Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ortant: if Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 27 No Directo Catonsville Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 7 Hay Pasture Court USA Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 Xes 2 No 1962
If Yes, Give Year or Dates: 1965 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐No 3altimore, Maryland 21215-0036 Specify: Specify: White <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Law 5+ Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Denver Tafton Clark Mary Helen Valeko ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Clark, Wife 7 Hay Pasture Court Catonsville, Maryland 21228 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Bunal 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 02/07/08 Baltimore, Maryland 21. Signature of Funeral Service Litensee ²² Name and Address of Facility Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 Thomas Gregor any 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ESOPHAYEAL CANCER, METASTATTC Due to (or as a consequence of): **Physician** MONTHS /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 4 Jnknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1∐ Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence & ther (Specify) HUS PLL Hospital: 1 ☐ Yes 2 2 0 မှ 1 Inpatient 2 □ ER/Outpatient 3 DOA this completely filled in by the funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Manner of Death 28c. Injury at Work? Certification: After 1 atural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No М death. 2 Accident after death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 Prestifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature D64395 eted cause of death (Item 23a) (Type, Print) 6565 N. CHAPLES ST, 8WITE 209 BALTIMORE, MA 21264 DANIEUE DOBERMAN MO 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 For State	State of M	larylan	-	artment of H		d Mental H		711117	3 03339
			Registrar 1. Decedent's Name (First, Middle, Last)			tineate of t	Jeani	2. Date of I	Reg. No	0.	3. Time of Death
	Physici /Medi		Raymond melvin	Chapma	n				Month		ay Year	111:00 P4
9	Examir		4a. Facility Name (If not institution, give	street and number,)		4b. City, Town, or		Jan.	25	c. County of De	ath
			Long Green Cen				Baltim				N/A	
	Funeral Director		5. Social Security Number 6. Se 244-68-3135 x 5	M 2□ F 7. A	ge (in yrs. i	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	lin. (Month, I	Birth Day, Year 10.	9. B 1941	irthplace (State or Foreign Country) N. Carolina
	Du .		Usual Residence of Decedent 10a. State 10b. County		100 Cit	y, Town or Lo	antion		~~~~	101		
	Aaryla Febo	ō	Maryland N/A		1	altimo						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	28a-	rect	10e. Street and Number				10f. Zip Code			10a. C	itizen of What C	1
	h with	ie O	2523 Park Heigh	nts Terr	cace		2121	5			JSA	
	deat	ner	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.	S. 13. V	Vas Decedent of Hi f Yes, specify Cuba		(Specify Yes or N			nerican Indian,
36	ges 1 and 2 should be filed within 72 hours effer death with the Maryland it of Heelth and Mental Hygiene. If flem 27 is marked other then "naturel", or Items 23s or 28s-f show or other traumatic event, the Medical Examinar must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:			I□Yes 2∏XNo	Specify:	one i neari, etc.)			Black
21215-0036	2 hou	ted	15. Decedent's Edu	cation		16a. Deced	lent's Usual Occupa	ation		16b. I	Kind of Busines	
212	e. "n	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work done of OO NOT use retired		working	Key	vstone	Electric
2	ygien ygien her th	S	Unk.			Elec	trician			Co	•	
Maryland	2 should be filed within and Mental Hygiene. Is marked other then "reumatic event, its Max	Be	17. Father's Name (First, Middle, Last)						Name (First, Midd La Smit		n Sumame)	
Ž	should nd Me mark matic	2	Sam Chapman 19a. Informant's Name/Relationship (Ty	ne Print)		19h Mailin	g Address (Street a				or Town State	Zin Code)
	1 and 2 s Heelth ar em 27 is		Christine Chapm									wa 21215
Sre,	es 1 a of He of He filtern r othe		20a. Method of Disposition	•	20b. PI	lace of Dispos	Park H sition (Name of natory or other place	erdura	Date	20c. l	altime Location - City of	or Fown, State
Ĕ	Pages ment of ent: If It ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			nt Ceme		4/08	Bal	timore	e,Maryland
Baltimore,	permit. Pages Department of Importent: If I eny injury or o		21. Signature of Funeral S. wice Licens	90		22	Name and Addres	s of Facility	Chatman	-Har	ris Fu	ueral Home
	40200		23a. Part1. Enter the disease, or combi	rations that cause	d the death	5.2	40 Reis	tersto	wn Rd	Balt		Maryland Approximate
	Diam'r.	4	shook, or heart failure. List only or	e cause on each li	ine.			-				Interval Between
	Physician /Medical		disease or condition resulting in death)	Due to (or as			MUNOD	eficie	MCA 2	YNZ	ROME	YEARS
	Examiner				a consequ	ience oi);						
	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ience of):						
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last									
8760,	cate be executed physician and the burial-transit			Due to (or as	a consequ	ience oi):						
687		edicai										
Box	death certifi e attending id for use as	IN/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome			.				23d. Date of de	elivery
	e deatl	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregnancy Other (specify)				Month	Day Year
J.	that the deed by the a	Phy	9 Unknown			Malana to M	4		00. 01.			
Vital Records,	8 6 g	d by	Part II. Other significant conditions con	induting to death b	out not resu	liting in the un	derlying cause give	n in Part I.				to the cause of death? Probably 4 Dunknown
Ö	s been si	olete							24a. Wa	s an	24b. Were a	autopsy lindings available
# H	0 5 0	Completed					·		- aut per 1 ☐ Yes	opsy formed? 2 2 No	prior to death?	completion of cause of
Ita	certificate	Be	25. Was case referred to medical examiner?					26. Place of D	eath Check only			20.10
6	shys this al dir	၉	1 163	ospital:		ER/Outpatient		4 Nursing	Home 5 ☐ Re			ecify)
	ding h. After fune	tion	27. Manner of Death 1/2 Natural 5 ☐ Pending 2 Naccident investigation	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	28c, Injury Work	at ? ′es 2 ⊡No	28d. Describe	how inju	ury occurred	
DIVISION	l or Attending after death. Director: After I in by the funer	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inj	ury - At hor	me, farm, stre		63 2 1140	28I. Location	(Street a	nd Number or F	Rural Route Number.
Ē	rs after	Certification;	4 Homicide determined	building, et	c. (Specify,)				own, Stat		
	To the Hospital or within 24 hours afte To the Funarel Dir completaly filled in	Medical	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best er: On the basis o and manner sta	i examinati	vledge, death ion and/or inv	occurred at the tim estigation, in my op	e, date and pla inion, death oc	ce, and due to the	e cause(s	s) and manner and place, and du	as stated. se to the cause(s)
	To the Mithin 24	Me					29c. License	number		29d. Da	ate signed (Mor	nth, Day, Year)
ł			1/200	Ill	11	S)	D	31136	,	To	NUAPU	30 2008
			30. Name and address of person who co BRAN WALLA 31. Date filed (Month, Day, Year) FEB 0 7 2	mpleted cause of d	leath (Item	23а) (Туре, Г	Print)	N 11 -		VIT	12411	50,200
			BRIAN WALLA	(E mis	900	5 KIL	BRIDE R	y, Beri	morre	pris	2123	6
	Sta Registra	te ar	FER 0 7 2	008 32. Hegistr	ars Signati	ure.	assis					
			e em tor	1	- 9	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Childs Doro The 2008 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Char1estown Baltimore Renaissance Gardens Catonsville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 🗓 F 216-32-4404 100 1907 Maryland Director May 29, Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits sa or 28a-f show t be notified at 10a, State Director 1 ☐ Yes 2√☐ No Maryland Baltimore Catonsville filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 709 Maiden Choice Lane, #210 South 21228 United States of America Funeral items ? 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or iten edical Examiner Black, White, etc. 1 Yes WNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XX No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Schools 12 Teacher s 1 and 2 should be filed in the still and Mental Hygic Item 27 is marked other other traumatic event, it other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lucien Hanna Nellie Mae Dean P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a mut. If item 27 is jury or other tra Thomas L. Childs (Son) 20671 Muddy Harbour SQ., Potomac Falls, VA 20165 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department or Important: If any injury or once. Metro Crematory Inc. 02/07/08 Catonsville, MD 21228 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Loring Byers Funeral Directors, Inc Kellner MOO 333 8728 Liberty Road, Randallstown, MD 21133-4784 23a. Part Enter tife disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Meu moni disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the burial-transi and Due to (or as a consequence of) physician for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 Yes 2 No detached 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy perform certificate 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) · To Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Inpatient After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b, Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

MO

Bowlin

Year)

Maryland 21215-0036

altimore,

The law requires that the death certificate be executed

or Attending Physician:

Hospital

Division or Vital Records, P.O. Box 68760,

nus

D 711 Maiden
32. Registrar's Signature

29c. License number

Choice Lune, Catonsville

29d, Date signed (Month, Dav. Year)

21228

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Paul Francis Creamer 05:00PM FEBRUARY Ø5. 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson Baltimore Center Saint Joseph Medical 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 X M 2 □ F 76 Director 016-24-8738 01/09/1932 MA Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at 10b. County 1 ☐ Yes 2 XNo Director MD Baltimore Cockeysville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or 16 Lord Mayors Court 21030 USA Funeral filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Manan injury or other traumatic event, the Manan injury or other traumatic event, the Manan injury or other traumatic event, the Mananatic event, the Mananatic event, the Mananatic event, the Mananatic event in Mananatic ev Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Sales Engineer</u> Electronics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold L. Creamer 2 Elizabeth G. Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Creamer/Wife 16 Lord Mayors Ct., Cockeysville, MD 20b. Place of Disposition (Name of Egyptery, crematory or other place)
Hillop Service
Corporation Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/08/2008 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensue 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, MD 21204 1050 York Rd., 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) RESPIRATORY FAILURE /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine sician and burial-transit the death certificate be executed INTRACRANIAL HEMORRHAGE resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, ng physician a Physician/Medical attending | IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>Ş</u> RENAL INSUFFICIENCY 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 ☐ Yes 2 ☐ No 1∐ Yes 2 No or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 3□ DOA P 1 Inpatient 2 ER/Outpatient funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) Injury 1 Natural 5 ☐ Pending within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu М 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FEB 07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

DHMH 17 Rev 1/2001

29c. License number

M. D. 76/31 OSLER DRIVE TOWSON, MARYLAND 212/04

D24034

29d. Date signed Month, Day, Year)

		For State Registrar	State of Maryland		ertificate of L		R	eg. No.	2008	03342
Physici		Decedent's Name (First, Middle, Last, JUDITH S	ARGOWITZ		CALLERI		2. Date of Dea Month FEBRUAR'	Day	2008	3. Time of Death 1:34P M
/Medio Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death			ounty of Death	
Funeral		8417 LOCH RAVEN B 5. Social Security Number 6. Security Number	7. Age (In yrs. Is	ast birthday		IMORE If Under 24 Hrs. Hours Min.	8. Date of Birth	Year)	9. Birthp	lace (State or Foreign
Director		213-46-4895 1L Usual Residence of Decedent]M 2 X F 60	Yrs.	World	TIOUIS WIIII.	07/18/1	.947		MD MD
aryland show d at	_	10a. State 10b. County		, Town or L					10d. Inside City Limits 1 ☐ Yes 2 🂢 No	
r 28e-f	recto	MD BALTIM	UKE	BAL	TIMORE 10f. Zip Code			10g. Citize	en of What Cour	
ath with	Funeral Director	8417 LOCH RAVEN				21234				SA
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28e-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	S. 13.	. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 【 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-		1. Race - Americ Black, White,	
hours tural", al Exa	ed by	3 ☐ Widowed 4 🎇 Divorced 15. Decedent's Edu	Year or Dates:	16a. Dece	edent's Usual Occupa				Specify:	WHITE
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ould be Mental arked attc ev	To B	ELI		ARGOW		RO.			ROSENSW	
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mit. Pa bartmen cortant: Injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Vicens	1//		ENS CIRCLE				IMORE, & BROS.	
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Physician		23a. Part. Enter the disease, or compl shock, or heart failure. List only o Immediate Cause (Final	ications that caused the death ne cruse on each line.	Do not er	ic Cand	g, such as cardiac	or respiratory are	rest, SockS	6	Approximate Interval Between Onset and Death
/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequ		te cond	i o vara c	4.5.	~~		
Examine	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):						
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To the Hospitel or Attending Physician: The law requires that the death cerwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely illied in by the funeral director, page 2 should be detached for use.	ysician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	□Ectopic pregnancy □ Other (specify)			23	3d. Date of deliv Month	ery Day Year
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To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Completed						autop		prior to co death? 1 ☐ Yes	ompletion of cause of 2000 No
rslclan s certifi firector	To Be	25. Was case referred to medical examiner? 1 ★ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	ent 3 DOA Othe	n et	ome 5 Resid		Other (Speci	(6.1)
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Attender death ector: by the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At ho building, etc. (Specify			Yes 2 No	28f. Location (S City or Tow	Street and	Number or Rur	al Route Number,
pitel or ours afte eral Dil filled in	Cert		sician: To the best of my know		ath cooursed at the time	no data and place			and manner as	ntatad
the Hos iin 24 ho the Fun tpletely	Medical		Iner: On the basis of examinat and manner stated.							
with To	Σ	29b. Signature and the of certifier	Donto		29c. Licenso				signed (Month	
1	4	39. Name and address of person who c	21 / -	1.1	e, Print)	- / 11	4(1	N.4	210	93
Sta	ite	31. Date filed (Month, Day, Year)	32. Reistrar's Signa	ture	P HILLCT	Luthe	vaille	1140	1 410	1.2
Registi	ar	FEB 0 7 2	1008 Barrer	#	294 3					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 4 200 8 **Physician** 8:02 AM FEBRUARY Francis Duclos /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) **Examiner** HOSPITAL BALTIMORE AGNES N/A 8. Date of Birth (Month, Day, Year)
Aug 19, 1 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 XM 2 ☐ F 86 Yrs. 1921 Indiana 572-01-6703 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 426 Stratford Road 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M/Yes 2 □ No If Yes, Give Year or Dates: 1945 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 73 and Mental Hygiene.

s marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Printer Printing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louise Rebhahn Regis A. Duclos 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1002 Frederick Road Catonsville, MD 21228 of Health Louis J. Weinkam, Jr., Attorney 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Important; If it any injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 02/06/08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Lideose Thomas Gregor Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a CHRONIC OBSTRUCTIVE PLILMONARY DISEASE Immediate Cause (Final YEARS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DISEASE YEARS CORONARY AFTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner YEARS ALTZHEIMERS DISEASE attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has the lirector, page 2 s 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ €R/Outpatient 3 ☐ DOA 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

I Director: /
d in by the f 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician:

Baltimore, Maryland 21215-0036

within 24 hours aft

To the Funeral Di

completely filled in

Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier ST AGNES HOSPITAL 31. Date filed (Month, Day, Year) State Registrar

Wernet

29c. License number D46505

29d. Date signed (Month, Day, Year) EEBRUARY 4, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE.

32. Registrar's Signature

08-00859

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 03344

Lance Ferreii Dav	1.		icate of	Death		- 7 5	Reg. No.	£ U (
Physicia		eqistrar I. Decedent's Name (First, Middle,Last)				2. Date of Dea	ath Day Yea		3. Time of Death 0249 hrs
M/G: ~ Examin	er	LANCE TERRELL DAVIS				Month January	31, 2008 4c. County	of Dooth	0249 1115
	4	4a. Facility Name (if not institution, give street and number)	41	o. City, Town, or Lo La Plata	cation of Dea	tn	Charles		
		Civista Medical Center 5 Social Security Number	hirthday)		If Under 24H	rs. 8. Date of E	irth (MM/DD/YYY	g. Birth	place (State or
Funeral	l	5. Social decarty Hamber	.,	Months Days	Hours M	in.		Foreign Cour	VIRGINIA
Director	- 1		23 Yrs.	<u> </u>		104/03	/1985		
any		Usual Residence of Decedent 10c. City, To 10a. State 10b. County 10c. City, To	own or Location	on				1	10d. Inside City Limits
D 00 0		Virginia	PETER	SBURG					1 X X Yes 2 No
rrylan Sa-f sl	휧	10e. Street and Number		10f. Zip Code			10g. Citizen of W	hat Count	ry?
he Mi	삞	1964 S. WESTCHESTER DRIVE		23805	5		U.S.		
with t	교	11. Marital Status 12. Was Decedent Ever in U.S.	13. Wa	s Decedent of Hispa es, specify Cuban, I	anic Origin? (Mexican, Pue	Specify Yes or I rto Rican, etc.)		e - Americ ite, etc.	an Indian, Black,
death	Funeral Director	1 X Never Married 2 Married 1 Yes 2 X No					Specify	BLA	CK
after ral", o	ğ	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	i Sn. Doceden	Yes 2 X No t's Usual Occupatio	n (Give kind o	of work done	16b. Kind of E		
hours hatu	<u>a</u>	Elementary/Secondary (0-12) College (1-4 or 5+)	during m	ost of working life. I	OO NOT use r	retired)			
36 in 72 ithan 'dical	e e	12th grade	MACH	INE OPERA	ATOR				NTAINER
-00 d with ygien of ther	Completed	17. Father's Name (First, Middle, Last)		18	8.Mother's Na	me (First, Middle	e, Maiden Surnam	ie)	
215 be file ntal H rked ent, t	Be	JOHN HENRY DAVIS	1.5	g Address (Street	THER	ESA BROV	IN City or To	own. State	Zip Code)
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	유	19a. Informant's Name/Relationship (Type, Print)							
ME nd 2 s alth ar mm 27		Theresa B. Davis/Mother 20a. Method of Disposition 20b. Pl	lace of Dispos	S. Westel	hester etery,	Date Date	20c. Locatio	n - City or	Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If itel		1 X Burial 2 Cremation 3 Removal from State	ematory or ot	•	,	00 05 00	Dimeri	aa: c	Virginia
timent trant:		4 Donation 5 Other Specify D1 21. ature of Funeral Service Licensee	1 00 1	e Mem. Pa	of Engility				
Bal permi Depar Impo	3	FYILLIAM (TIME	WI	LLIAM C	BROWN (VENILE			
Physician		23a. Part I. Enter the disease, or complications that caused the death.	Do not enter	the mode of dying, s	such as cardia	ac or respiratory	arrest, shock, or	neart	Approximate Interval Between Onset and
(ledical	- 3	failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive athe	rosclero	otic cardio	vascular	disease			Death
.aminer		or condition resulting in death) Due to (or as a consequence of):						
	<u>.</u>	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of);						
	Examiner	cause. Enter Underlying Cause							
d d	xar	events resulting in death) Last Due to (or as a consequence of):						
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60, ate be ex hysician e burial	legi	IF FEMALE: 23c. If yes, outcome of pregi		1/08 TT				e of delive	
876 tificat ng ph	Ž	23b. Was decedent pregnant in the past 12 months?	2 F	etal death 3	Ectopic pr	egnancy	Mont	ו	Day Year
Box 687(e death certifica the attending pl ed for use as th	sicia	past 12 montus? 4 Pregnant at time of de 1 Yes 2 No 9 Unknown g Unknown	ath 5 (Other (Specify)			-		
of Vital Records, P.O. Box 6876 ing Physician: The law requires that the death certifica After this certificate has been signed by the attending phinneral director, page 2 should be detached for use as the funeral director, page 2 should be detached for use as the	Physician/Medical	Part II. Other significant conditions contributing to death but not re	esulting in the	underlying cause g	given in Part I				o the cause of death?
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ds, l	Completed						Vas an 24	b. Were a	autopsy findings available completion of cause of
COFC law re has be	뺼					_ _	performed? (es 2 No	death?	
of Vital Records, P.O. ng Physician: The law requires that it when this certificate has been signed by meral director, page 2 should be dested meral director, page 2 should be dested	් වි			26.Place	e of Death (C	heck only one)			
ital sician: s certi	å	examiner? Hospital:	ER/Outpatie	nt 3 DOA	Other 1	Nursing Home	Residence	6 Oth	er:
n of V ling Phys After thi funeral d	l.	27 Manner of Death 28a. Date of Injury	28b. Time o	f Injury 28c. Inju	ury at Work?	28d. Desc	ribe how injury or	curred	
Sion C Attending death. Sctor: Af	<u>[</u>	1 X Natural 5 Pending			Yes 2 N				N - b - Cit
Division falor Attendi rs after death. al Director: A led in by the fi	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At h	iome, farm, st	reet, factory, office	building, etc.	28f. Locat or To	ion (Street and N wn, State)	umber or I	Rural Route Number, City
Divisi ospital or At hours after d meral Direct	Certification:	determined (Specify)				17			Later d
Hos Fur Fur			ige, death oc	curred at the time, og gation, in my opinio	date and place on, death occu	e, and due to the irred at the time,	cause(s) and ma date and place, a	nner as st and due to	the cause(s)
To the Hos within 24 h within 24 h Co the Fur	Medical	and marrier stated.			ise number		29d. Date	signed (f	Month, Day, Year)
	2	29b. Signature and title of certifier			.M.E.		Februa	ry 1, 20	08
		A death (the	m 23a)						
OCME	E	30. Name and address of person the completed caus of death (liter Mary G. Rypple MD. Deputy Chief Medical Exa		11 Penn Stree	et, Baltimo	re, MD 2120	1		
0	Stat	many company		-4					
Reg		FFR 0 7 7000 1 200 - 3	T An	Early 1					
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amend item 20a per fh 8876 2-15-08 vt
amend #20b Per FH G876 2/13/08 III

Certificate of Death

Reg. No. 2 0 0 8 Reg. No. 2 U U 8 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death .Month **Physician** 00 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Maris SOICE Age (In yrs. last birthday) a Himore 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Aguntry) 1 M 2 □ F Months Hours Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 Nes 2 No Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2120 "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5:45 1 ☐ Yes 2 No Specify: þ Specify: 3 Nidowed 4 Divorced a Completed Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rund) Route Number, City or Town, State, Zip Code) FEBRUARY 20b. Place of Disposition (Name of complexy, Cognition of other place) DOWLER 20a. Method of Disposition 2/0972008 20c. Location - City or Town, State Pages 1 1 Burial 2 A Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address Facility
JOSEPH L. TYS
2222 W. NOTTO 21. Signature of Funeral Service Licensee Funeral 23a. Part 1. Enter the disease, or complications that caused shoots or heart failure. List only one cause on each lin ed the document. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 51 20/47E Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the detached 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ROGER DOWER δ =1 mbosn 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an director, page 2: autopsy performed?

1 Yes 2 No this certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Hospital: 1 Tyes 2**X** No P 1 Inpatient 2 ER/Outpatient 3 DOA o 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Aftert Certification: Injury at Work? 1 X Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the Funeral Director: npletely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicar Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 4.08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDDIE NAKHUDA 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 2008

DHMH 17 Rev 1/2001

Registrar

2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Ester 12:16 PM rebnan 2008 /Medical 4a. Facility Name (If not institution, give street and number) b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A Hourbor Hospital If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Numbe 215–34–2363 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y Jun. 19, 9. Birthplace (State or Foreign **Funeral** Year 1 □ M 2 🔀 F 69 Maryland Director 1938 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County show 10d. Inside City Limits r 28a-f show notified at Baltimore MD Baltimore 1 □Yes 2 No Director 10e. Street and Number 2811 Oak Grove Avenue 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or the Medical Examiner must be r 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Specify: White Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u>Homemaker</u> Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ages 1 and 2 should be fill out of Health and Mental H: If item 27 Is marked oth y or other traumatic even! Be George Himmel Dorothy Eckland မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Gareis - Daughter 2813 Oak Grove Ave., Baltimore, MD 21227 20b. Place of Disposition (Name of Grentery, crematory or other place)

A complete of Disposition (Name of Place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department or Important: If any Injury or Glen Burnie, MD 5 ☐ Other (Specify) al Park 2-6-2008 Gien Burnie, MD

22. Name and Address of Facility Ambrose Funeral Home of Lansdowne Memorial Park Signature of Auneral Service License 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. To not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or is a consequence of): **Physician** day /Medical Examiner Spirator Sequentially list conditions, if any, leading to infine data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner (to solvenueena) The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as the b 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 I Inknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification: To this in by the funeral 27. Manner of Teath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? after death. 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident o the Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Within 24 hours a To the Funeral I completely filled Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000 PHYSICIAN February, 2,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore IMD 21225 Itamzenzadeh Sayen S. Howover Street 3001

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

gistrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0008

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1-	For State Registrar
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			1 - State Registrar	,	Ce	ertificate of	Death	R	eg. No.	
	Dbi.		1. Decedent's Name (First, Middle, La					2. Date of Deat Month	h Day Yea	3. Time of Death
	Physici /Medio		Myrtle	M. Freder	rick			February		8:45 AM M
¥.	Examir		4a. Facility Name (If not institution, given	e street and number)		4b. City, Town, o	r Location of Deat	th	4c. County of De	
			Golden Living Cer	· · · · · · · · · · · · · · · · · · ·		Westm			Carroll	
	Funeral Director		210 03 0070	Sex 7. Age (II I ☐ M 2 🔯 F	93 Yrs.	Months Days	If Under 24 Hrs Hours Min		9. E 914 M	Birthplace (State or Foreign Country) aryland
	and w		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or L	ocation				10d. Inside City Limits
	he Maryl 28a-1 eho pullied a	ector		1 County	Westm	inster			0 00 00	1 □Yes 2√∑No
	ath with t	Funeral Director	1234 Washington F			10f. Zip Code	21157			SA
920	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other then "naturel; or Items 23a or 28s-f show imalic event, it a Mudical Examination in the position as	<u>ک</u>	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2XXIo If Yes, Give Year or Dates:	r in U.S. 13.	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2♥♥No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Al Black, W Specify:	merican Indian, hite, etc. white
Maryland 21215-0036	within 72 h ane. then "natu	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		(Giv life.	edent's Usual Occup e kind of work done DO NOT use retired	ation during most of wo d)	prking	16b. Kind of Busine In own	,
land 2	buld be filed within 72 Mental Hygiene. arked other then "nat atic event, tra Medici	To Be Co	8 17. Father's Name (First, Middle, Last Benjamin Biles)				me (First, Middle, M Alder		
	ages 1 end 2 should b nt of Health and Ment: t: if item 27 le marked / or other treumatic e		19a. Informant's Name/Relationship Donald Frederick	Турв, Print) Son		ling Address (Street Nicodem			, City or Town, State dsor, Mar	
Baltimore,	Pages 1 e nent of He int: If item iry or othe		20a. Method of Disposition 1204Burial 2 Cremation 3 [4 Donation 5 DOther (Special	Removal from State		osition (Name of ematory or other place Park Cer			20c. Location - City Woodlawn,	or Town, State Maryland
Balti	permit. Page Depertment of Important: If eny Injury or		21. Signature of Funeral Service/Lic	up the		22. Name and Addre Burgee—Her 3631 Falls		z Funeral Baltimor	Home, In e, Maryla	.C. nd 21211
	Physician /Medical		23a. Fartt Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the one cause on each line. a Due to (or as a co	death. Do not en					Approximate Interval Between Onset and Death
	Examiner	niner	Sequentially list conditions, is ny, sacing to incrediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a co						
68/60, /	death certificate be executed e ettending physicien and ind for use as the burial-transit	ai Examiner	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):					
200	ificate g physi as the t	Medicai	()	0.						
O. Box	at the death certific: by the ettending pl tached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify) _	,		23d. Date of Month	delivery Day Year
ds, P	signed d be de	۵	Part II. Other significant conditions	contributing to death but n	ot resulting in the	underlying cause giv	en in Part I.	23e. Did tob		e to the cause of death? Probably 4 □Unknown
Hecord	e law hes b	Completed	<u> </u>					24a. Was a autops perform 1 \(\text{Yes} \)	y prior t ned2 death	autopsy findings available to comptetion of cause of
Vital	iclen: Th certificate rector, pag	a	25. Was case referred to medical				26. Place of De	ath Check only on		65 2 100
	8 8 8	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatie	ent 3 DOA Oth	er: Nursing I	Home 5 ☐ Reside	ence 6 Other (S	pecify)
lon of	Attending Pt ir death. ector: After th by the funeral		27. Mannenof Death 1 Natural 5 □ Pending 2 □ Accident investigatio	28a. Date of Injury (Month, Day Ye	28b. Time lnjury	Wor	yat k? Yes 2 □No	28d. Describe ho	ow injury occurred	
DIVISION	o it to	Certification:	3 Suicide 6 Could not be 4 Homicide determined		At home, farm, s Specify)	treet, factory, office		28f. Location (St. City or Town	reet and Number or n, State)	Rural Route Number,
	To the Hospital within 24 hours a To the Funerel Completely filled	edicai	(Check only 2 Medical Examone)	nysician: To the best of m miner: On the basis of exa and manner stated	amination and/or i	ith occurred at the tir nvestigation, in my o	ne, date and plac pinion, death occ	e, and due to the ca urred at the time, d	ause(s) and manner ate and place, and c	as stated. Jue to the cause(s)
)	To the within 2 To the complete	Σ	29b. Signature and title of certifier	C. M	f M.	29c. Licens 0, 000	5955	2	9d. Date signed (Mc	onth Day, Year)
	6		30. Name and address of person who	2 CMBG	must	Print)	Page R	e LESTI	NIN STER	MD 21159
4	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 7 20	32 Registrar's	Signature	and the				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar Amend #1, perl	D,g876, 2/7/08 TI	Ce	rtificate of l	Death	Re	g. No L	JUU	03349
		1. Decedent's Name (First, Middle, Las	Ucille Catheri	ne Gre	en.		2. Date of Death Month	Day	Year	3. Time of Death
Physicia /Medic		Lucille Catho	erine E				January	28	2008	11:40 PM
Examin	100	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	,	4c. Count	y of Death	
	ings.	Sinai Hospital	of Baltimore		Balt	more		N/	A	
Funeral		5. Social Security Number 6. Se	7. Age (In yrs. I	ast birthday		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpla	ace (State or Foreign
Director		219-30-9181	□ M 2 X F 83	Yrs.	World bays	Hours Ivini.		19	L .	aryland
TO		Usual Residence of Decedent						, , ,		
nylan how at		10a. State 10b. County		, Town or L					10	d. Inside City Limits
a-f s	cto	Maryland N/A	I	Balti	.more					Y∏Yes 2 No
th the	Director	10e. Street and Number			10f. Zip Code	_	10	-	What Count	ry?
h wit		6847 Parsons Av	enue		2120	/		USA		
dea	Funeral	11. Marital Status	12. Was Decedent Ever in U.: Armed Forces?	S. 13.	. Was Decedent of H If Yes, specity Cuba	lispanic Origin? (Sp an. Mexican, Puerto	ecify Yes or No-		ce - America	
after or ite mine		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2 ☐XNo	Specify:	,	Speci	D1	ack
ours ral"; Exa	d by	3 Widowed 4 □ Divorced	Year or Dates:					Ореч	.,.	25-2
72 h natu dical	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	edent's Usual Occup e kind of work done o	during most of work		6b. Kind of I	Business/Ind	ustry
ithin le. Mer	ldu	Elementary/Secondary (0-12)	College (1-4or 5+)	Cook	DO NOT use retired	d) -	T	ixie	Dine	r
ygier ygier t, th	S	8th grade 17. Father's Name (First, Middle, Last)				10.11.11				
be fill H d out	Be		longon				e (First, Middle, M	aigen Surna	me)	
Men arke	ဥ	George H	enson	1		Mary				
2 sho and Is m		19a. Informant's Name/Relationship (7	ype. Print)	19b. Mail	ling Address (Street	and Number or Rui	ral Route Number,	City or Towi	n, State, Zip	Code) 22
and ealth n 27 ier tr	1 8	Joanne Rita Bur	ris/ Daughte	r 68	347 Parso	onm Ave	Baltir	nore,	Maryl	and
of He		20a. Method of Disposition 1 ☐ Burial 2XCremation 3 ☐	Romoval from State	emetery, cre	oosition (Name of ematory or other plac	ce) ¦			- City or Tov	
Pag nent int: 1		4 □ Donation 5 □ Other (Specify		eenmo	ount Ceme	ete ? /1/(08 Ba	altim	ore,M	laryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Euneral Service Licen	sey	2	22. Name and Addre	ss of Facility Cha	atman-Ha	arris	Fune	ral Home
e a E e	10	Derry 1	aris	5	240 Rei:	stersto	vn Rd _{Ba}	altim	ore,	Md 21215
***		23a. Part1 Enter the disease, or comp shock, or heart failure. List only	plications that caused the death	n. Do not er	nter the mode of dyir	ng, such as cardiac	or respiratory arre	st,	1	Approximate Interval Between
Physician	0.1	Immediate Cause (Final								Onset and Death
/Medical		disease or condition resulting in death)	a. Due to (or as a consequ		Dementi	4			-	
Examiner										
_ 2 <u>**</u>	F.	Sequentially list conditions, if any, leading to immediate consider the conditions of the conditions o	b. Due to (or as a consequ	uence of):						
nsit	ië	Cause (Disease or injury								
icate be executed physician and s the burial-transit	Examiner	resulting in death) Last	C	uence of):						
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The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Medical		. d							
leath certific attending p I for use as t		IF FEMALE:	23c. If yes, outcome pf pregna	incy				23d E	ate of delive	D/
eath atter for u	Physician	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	death 3	☐ Ectopic pregnancy ☐ Other (specify)	У				Day Year
he d the	ysic	1 □ Yes 2 🗷 No 9 □ Unknown	9□Unknown	oua, o						
w requires that the d been signed by the should be detached	占	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the	underlying cause giv	en in Part I.	23e. Did tob	acco use co	ntribute to th	e cause of death?
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The law	ပ္ပ						perform 1 Yes 2	No No	death? 1 ☐ Yes	2□ No
sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			12.		th <i>(Check only one</i>	9)		
hysle his c	2	1 ☐ Yes 2 🔀 No		ER/Outpatie		4 Li Nui sing 11	ome 5 Reside)
ng P fter t nera	Ë	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury		ry at rk?	28d. Describe ho	w injury occ	urred	
endl ath. or: A he fu	aţi	2 ☐ Accident investigation			M 1□	Yes 2 □ No				
r Att	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Specifical Control of the control	ome, farm, s y)	street, factory, office		28f. Location (Str. City or Town	eet and Nur , State)	nber or Rura	l Route Number,
Ital or rs aft all or a	Certification:									
losp hou uner uner	cal		ysician: To the best of my kno niner: On the basis of examina							
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p.	ledical	one)	and manner stated.							
To 1 To 1	Σ	29b. Signature and title of certifier			29c. Licens	se number	29	∂d. Date sigr	ned (Month, i	Day, Year)
				Δ.	Δ5	59062		Janua	ry 29	2008
((1)		30. Name and address of person who	completed cause of death (Item	23a) (Type	e, Print)				/	
		Chad Hansen	2401 W Be 32. Registrar's Signa 2008	Ivedera	Balt.	more MA	21215			
Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	donet!					
 Registr 	rar	FEB 0 7	ZUUO ANTONIO	De 1	7					

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician Februsny 1. 40 PM 12 2006 /Medical acility Name (If not institution, give street and number) County of Death ty, Town, or Location of Death Examiner MOD 141000 unthwest 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

March 23,1920 Washington 7. Age (In yrs. last birthday **Funeral X**i**X** M 2□ F Months Days Hours 537-09-8956 87 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes XX No MD Baltimore Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7502 Sudbrook Rd. 21208 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? XiXi Yes 2 □ No If Yes, Give Year or Dates: WW I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 □ Yes XX No Specify WW II Specify: ρ 3 Widowed 4 Divorced White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronic Engineer Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Grichuhin Maria Gavrilov 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yole Grichuhin / Wife 7502 Sudbrook Rd. Baltimore, MD 21208 20a. Method of Disposition
1 ☐ Burial XXCremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc. 2/7/08 Baltimore, MD 21. Signature of hal-Service Licensee 22. Name and Address of Facility Eckhardt Funeral chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that cons, d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each one. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MEUMONIA /Medical Due to or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 9 Unknown 9 Unknown Part II. 9th r significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 □ No 3 Probably 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2 **X** No 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA this After thi funeral 27. Manner of Death 1 D Natural 2 D Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours are.

To the Funeral Director: After completely filled in by the fur

DHMH 17 Rev 1/2001

State Registrar

steven Fullon

29b. Signature at

30. Name and addr

title of certifier

ess of person v

ho completed cause of death (Iten

2. Registrar's Signature

'VQI

ORIGINAL

(out

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** GRANS VINOVIE 2008 JANVARY 30 /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner BALKIMTRE ANDAZLST MORTHWESK HESPYAL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1□M 2√2F 217-26-2384 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State 28a-f show d other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director M) Baltimore Windsor Mill 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 7572 Maury Road 21244 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married specifAfrican-American 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore County School Elementary/Secondary (0-12) College (1-4or 5+) **Ostodian** System Pages 1 and 2 should be filed vent of Health and Mental Hygie int. If item 27 is marked other? 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cleophus Boozer Willie Mae Moon permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any injury or other traumatte events. ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elaine Bell/Daughter 7572 Maury Road, Windsor Mill, MD 21244 20a. Method of Disposition

AB Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore Nat'l Cemetery 20c. Location - City or Town, State 2/6/08 Baltimore, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility While Funeral Rime P.A. of 3alto. Co. 1. Signature of Funeral Service License 9200 Liberty Rd., Randallstown, MD 21133 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARTERITSCLEADIL CARDIDVASCULAR **Physician** /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and y The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical use as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autops; performed? autopsy 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fi 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 0 0024970

3

State Registrar CLIFF FABER, MD
31. Date filed (Month, Day, Year)

PI PLO COURT RIAD, RANDAZZSTOWN

22. Registrar's Signature

Legan St. Specific

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5401

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2:35A M FRANK N. GLORIOSO FE12 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examine N/A GOOD SAMARITAN HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Min Months Hours 1 □XM 2 □ F 80 216-20-4571 DEC. 6,1927 LA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County N/A BALTIMORE 1 □XYes 2 □ No Director MD 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code USA 21206 Funeral 4607 BAYONNE AVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □X'es 2 □ If Yes, Give Year or Dates: 2 □ No 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo Specify Specify: WHITE Completed by 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Mason Union Tile Setter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SADIE D'AMICO PAUL GLORIOSO ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 104 QUEENSBERRY RD BALTIMORE, MD 21237 AMY RYNES-DAUGHTER 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition HOLY TRINITY RUSSIAN 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 2/5/08 ELKRIDGE, MD 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21206 6415 BELAIR RD 23a. Part1 Enter the disease shock, or heart failure Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stoply one cause on each line. Immediate Cause (Final SHOCK CARIDIOGENIC disease or condition resulting in death) Due to (or as a consequence of): MYUCARDINE INFARCTION Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CONGESTIVE MEART Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 4 Onknown MYPERTENSION CORONARY 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes _2 ☑ No 24a. Was an HYPER LIPIDEMIA autopsy 1☐ Yes 2☐ No .2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 5 ☐ Pending investigation (Month, Day Injury 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760.

The law requires that the death certificate be executed and attending physician sate has been signed by the page 2 should be detached After this certificate has funeral director, Director:

Funeral

Director

ns 23a or 28a-f show must be notified at

or Items

Injury or other traumatic event, the Medical Examiner

Department of Important: If its any Injury or o once,

Physician

/Medical

Examiner

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marked other than

death with the Maryland

Maryland 21215-0036

Baltimore,

FRAN X

Hospital or Attending Physician: within 24 hours at To the Funeral D

State Registrar

Medical

determined

mi

400D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 ☐ Homicide

(Check only one

29b. Signature and title of certifier

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

SAMARITAN HOSPITAL

29c. License number

KES 000

29d. Date signed (Month, Day, Year)

02,02, 5601 LOCH RAVEN

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Registrar

death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Dundalk MD 21222

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [] Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** Month Day 1105 AM February Charles L. Hoffmeister 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** PANNAUA NICANICO 50/15/11/1 If Under 1 Year | If Under 24 Hrs 6. Sex Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 1 ☑ M 2 ☐ F 0972971951 56 MD Director 217-56-5266 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Midical Examiner must be notified at once. 10d. Inside City Limits 1 ☐ Yes 2X No Directo MD Sussex Selbyville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19975 38222 Lookout Lane USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Maryland 21215-0036 White 1 ☐ Yes 2 1 No δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grocery Manager Giant Food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles A Hoffmeister Mildred N. Scheler 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia Hoffmeister/Wife 38222 Lookout lane Selbyville MD 19975 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 02/08/08 Bayview Crematory Baltimore MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCVI **Physician** disease or condition resulting in death) 1 year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) I□Yes 2□No 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 **□1**√0 3 ☐ Probably 4 ☐ Unknown 1 🗆 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed' 1 Yes 2 10 No Medical Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a, Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funera 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year) I wan Natyon February 5/2 2008 DO51359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. USITA

Registra DHMH 17 Rev 1/2001

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SALISBURY

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32 Registrar's Signature

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31. Date filed (Month, Day, Year)

FEB -

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

amend item State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 0917PM Thelma C. Holloman 000 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner altim n/a Birthplace (State or Foreign Country) Year If Under 24 Hrs. 6. Sex Age (In yrs. last birthday Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🕶 F Director 224-36-5857 North Carolina 78 11/4/29 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 ☐ No Director MD n/a Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21229 death v Funeral 3320 Benson Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 ₩ Widowed 4 □ Divorced Indian, Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sandy Chavis Leslie Jacobs ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7096 Saddle Drive Eldersburg, Maryland 21284 <u>Cathy Hagy / Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 2/9/08 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 21. Signature of Funeral Service Lice 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or c shock, or it art failure. List o Immediate Cause (Final disease or condition resulting in death) Physician 08 /Medical Due to or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 XNo 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of page 2 has autopsy performed death? 1 ☐ Yes certificate 1∐ Yes 2□ No 2 110 director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 1 🔲 Inpatient 3☐ ER/Outpatient 3☐ DOA P filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural 5 ☐ Pending investigation al or Attendi s after death. death. 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a the Hospital the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Nime and address of person who completed cause of death (Item 23a) (Type, Print) 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

08-00902 Donald Hubble

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		- For State Registrar	, , , , , , , , , , , , , , , , , , , ,	Cert	ificate of	Death				Reg	No.	. 0 0	0 0000
Physicia		Decedent's Name (First, Middle,t	_ast)						2. D	ate of Death	oav Ye		3. Time of Death
edical Exami		Donald Wayne Hu	ıbbel						F	onth [ebruary 1,	2008	u.	1430 hrs
		4a. Facility Name (if not institution,		r)	4	b. City, Town	, or Lo	cation of I			4c. County		
		Upper Chesapeake Hea	alth			Bel Air					Harford		
Funeral		Social Security Number 6	. Sex 7. A	ge (In yrs. las	st birthday)	If Under 1	_	If Under		Date of Birth	(MM/DD/YYY		nplace (State or Foreign ntry)
Director		212-90-9708	1X M 2 F	42	Yrs.	Months	Days	Hours	Min.	2-27-1	965	Ma	ryland
	- 1	Usual Residence of Decedent											
any	ı	10a. State 10b. County		10c. City, 7	Town or Locati	on						ľ	10d. Inside City Limits
ф 10 м		Maryland Har	ford		Bel Ai	r							1 Yes 2 X No
Sa-fs	윉	10e. Street and Number				10f. Zip Coo	le	•		100	. Citizen of W	hat Count	try?
death with the Maryland or items 23a or 28a-f show any must be notified at once.	Funeral Director	772 Handamaan Pa	1			210	14				U.S.A.	_	
ith th	등	773 Henderson Ro	12. Was Deceder	nt Ever in U.S	3. 13. Wa	s Decedent o		nic Origin	n? (Specif	y Yes or No-	14. Rac	e - Americ	can Indian, Black,
ath w	e l	1 Never Married 2 X Marr	ned Armed Force		If Y	es, specify Co	ıban, N	Mexican, F	Puerto Rica	an, etc.)	Whi	ite, etc.	
ter de		3 Widowed 4 Divor	1 Yes	2 X No	1	Yes 2X	No .	specify:			Specify	Whi	te
irs af iural imin	ð	15. Decedent's Education (Specif	. Lor Dates:	ompleted)	16a. Deceden					done	16b. Kind of E	Business/Ir	ndustry
2 hou "nat	ĕ	Elementary/Secondary (0-12)	College (1-4 c	or 5+)	during m	ost of working	life. D	O NOT u	se retired)	1			
5-0036 led within 72 hou Hygiene t other than "nat	Completed	12		i	Fire F	'ighter	•				Balt.	City	
d wit	녌	17. Father's Name (First, Middle, L	.ast)								aiden Surnam	ne)	
21215 ald be file Mental H marked o	Be	Wayne Hubbel							Sei				
	2	19a. Informant's Name/Relationshi									per, City or To	own, State,	, Zip Code)
MD 2 d 2 shoul lth and M m 27 is m	Ė	Diane M. Hubbel	l (Wife)		773 H	lenders	on	Rd B		ir, MD			
Baltimore, MC permit. Pages I and 2 s. Department of Health an Important: If item 27 injury or other traum:		20a. Method of Disposition 1 Burial 2 X Cremation	0 D		Place of Dispos rematory or ot		of ceme	etery,	D	ate	20c. Location	n - City or	lown, State
Baltimore, permit. Pages I an Department of Hee Important: If ite		4 Donation 5 Other Spe		State	yview C		ry		02-0	7-2008	Balti	more,	Maryland
Baltin permit. P Departme Importar		21 Signature of Funeral Service L	censee			Name and Ad		of Facility					e of BelAir
Balt permit. Depart Impor		Diane &	Ina Oc	2	In	nc. 610) W.	Mac	Phai	l Rd B	el Air	, MD	
Physician		23a. Part I. Enter the disease, or o	omplications that caus	ed the death.	Do not enter t	he mode of d	ying, s	uch as ca	rdiac or re	spiratory arre	st, shock, or h	neart	Approximate Interval Between Onset and
Medical		failure. List only one cause of Immediate Cause (Final disease	a. Hypertensi	ve athe	msclem	tic car	li ova	ascula	ar disa	ease			Death
kaminer		or condition resulting in death)	Due to (or as a co			CIC COIL							
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687 certifica nding p	ician/I	23b. Was decedent pregnant in the past 12 months?			_	etal death	3	Ectopic	pregnanc	У	Month	1 [Day Year
Box 687 ne death certific the attending p	sici	1 Yes 2 No 9 Unki		at time of de	ath 5 O	ther (Specif))						
Be deep the street of the street for	Phy	Part II. Other significant condition	J Olikilowi		coulting in the	underlying	use di	ven in Pa	rt I	23e. Did to	bacco use co	ntribute to	the cause of death?
rds, P.O. v requires that the s been signed by t	by F	Part II. Other significant condition	oris contributing to de	saur but not r	esulang in the	underlying of	iase gi	VOI 111 G					bably 4 V Unknown
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Of 1g Pt (fter meral	=	27. Manner of Death	28a. Date of (Month, D	Injury ay,Year)	28b. Time of			y at Work	,	8d. Describe	how injury occ	curred	
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Division tall or Attendians after death.	fica		tigation 28e. Place of	of Injury - At h	ome, farm, str	eet, factory, c	ffice bu	uilding, et	c. 2	8f. Location (mber or R	ural Route Number, City
Divi Hospital or 24 hours afte Funeral Dit	Certification:		mined (Specify)										
Hosp 24 ho Fune stely f	a	29a. Certifier 1 Certifying Ph	nysician: To the best of	f my knowled	lge, death occi	urred at the ti	ne, da	te and pla	ace, and di	ue to the caus	se(s) and mar	nner as sta	ited.
Division To the Hospital or Atterwithin 24 hours after dea Within 24 hours after dea To the Funeral Director completely filled in by th	Medical	one) 2 Medical Exar	niner: On the basis of and manner stat	examination a	and/or investig				curred at t	ne time, date			
F \$ F S	≥	29b. Signature and title of certifie						e number					onth, Day, Year)
		Marchan	well M	-		1	1.O.C	M.E.			Febr∪ar	y 2, 200	8
		30. Name and address of person	who completed cause	of death (Item							•		
+		Melissa Brassell, MD	Assistant Medi	cal Exami	ner 111	Penn Stre	et, B	altimor	e, MD 2	1201			
	tate	31. Date filed (Month, Day, Year)	2008 32 Regi	strar's Signat		1							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Kathleen Millner Hockman /Medical 4a. Facility Name (If not institution, give street and number) . County of Death **Examiner** 4b. City, Town, or Location of Death Doctor's Hospital P.G. Lanham If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 X F 72^{Yrs.} **Director** 03-15-1935 Virginia 215-36-4670 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Director MD Prince Georges Capital Heights, MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 608 Opus Avenue 20743 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐Yes 2 No f Yes, Give 'ear or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White þ 3 ₩ Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa Completed ltimore, Maryland 21215-0 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unemployed N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Millner Maude Millner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 608 Opus Avenue, Capital Heights, MD 20743 Donna Hockman/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veteran Cem 02-11-2008 Chelteham, MD 21. Signature of Funeral Service vicen 22. Name and Address of Facility Marshall's Funeral Home of MD D. CRM 4308 Suitland Road, Suitland, MD 20746 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** monly /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed Due to (or as a consequence of) ed by the attending physician detached for use as the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9□Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been sly 1 🗌 Yes 2 No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? res 22No 1∐ Yes Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 1 Inpatient 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03358 Reg. No. 2 U U 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 4, 2008 **Physician** Clarence H. Hinke 7:20 ам /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2806 Evergreen Avenue Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 16, 1927 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1X M 2 □ F 218-22-2674 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2806 Evergreen Avenue 21214 USA by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married WII Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Maintenance Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph R. Hinke Matilda Puls 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Hinke/ Wife 2806 Evergreen Avenue Baltimore Maryland 21214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus 2/7/08 Dundalk Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leopard J. Ruck Inc. 5305 Harford Road Baltimore Maryland 21214 huster 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Obstructive Pulmonary **Physician** nronic 15 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine burial-tran the death certificate be executed and Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical the as for use a IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed cancer 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed After this certificate 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural To the Hospital or Attendii within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 🔀 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CYNTHIA BOYO, m. J. 5505 HOPKINS BAYVIEW CITCLE Baltimore, Haryland

29c. License number

D0057866

29d. Date signed (Month, Day, Year) February 6, 2008

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	Funeral	
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Physician

/Medical

10a. State

MD

Director

Funeral

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Examiner

Funeral

Director

Show

"natural", or items 23a or 28a-f shov dical Examiner must be notified at

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

within 24 hours a To the Funeral L

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 5, 1:45 PM Darrell Reade February 2008 Hopkins 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3120 Saint Paul Street #410E Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 56 015-38-7676 Feb 25, 1951 Massachusetts Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3120 Saint Paul Street #410E 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black. White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Specify: 1 ☐ Yes 2 🛛 No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Petroleum Industry Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roberta C. Reade George Hopkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances H. Hopkins/wife 3120 St. Paul Street #410E Baltimore, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 02/07/08 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 22. Name and Address of Facility Going Home Cremation Service P.O. Box Beverly L. Heckrotte, P.A. Clarksville, 21. Signature of Funeral Service License P.O. Box 784 MD 21029 Me MO1251 23a. Part1. Enter the sease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final antle disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No pertorm 1□ Yes 2 🔯 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year)

physician and s the burial-trans use as t for ned by the a been signe should be c has le 2 certificate has irector, page 2 this funeral nours after death.

Examiner

Physician/Medical

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Completed

Be

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Certification:

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IF FEMALE

Physician

/Medical

Examiner

1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1XYes 2 No 27. Manner of Death 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29c. License number

29d. Data signed (Month, Day, Year)

10

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1650 Orleans St. Baltimore, MD 21205 Richard Jones, M.D.

31. Date filed (Month, Day, Year) FEB 0 7 2008

29b. Signature and title of confiler

NAC 08-00842 UNK UNK

HUNT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death . Decedent's Name (First, Middle,Last) Month Day January 30, 2008 1245 hrs Medical Examiner Wn 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Johns Hopkins Hospital - Bayview 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number 6. Sex Funeral Foreign Months Days Hours Min. Director Country) 1 X M 2 Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town of Location 10a, State Yes 2 No or items 23a or 28a-f show must be notified at once. Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number Funeral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married imore, MD 21215-0036

Pages I and 2 should be filed within 72 hours after of near of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", on or other tranumatic event, the Medical Examine." Specify: Divorced If Yes, Give Year Yes 2 No specify: Widowed 4 ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Syrname) ne (First, Middle, Last Be 19b. Mailing Address ral Route Number, City or Town, State, Zip Code 19a, Inform Baltimore, MD ity or Town, State 20c. Logation -C 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Burial Cremation 3 Removal from State 2 02-07-08 Other Specify Donation 5 21. Signature of Funeral Service Licensee Rivermon Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical a. Gunshot Wounds (2) of Torso Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate raust. Enter Underlying Couse (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - tran Physician/Medical UNPENDED **AMENDED** attending physician or use as the burial The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown g Unknown ned by the a 23e. Did tobacco use contribute to the cause of death? <u>о</u>. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Yes 2 ✔ No 3 Probably 4 Unknown Records, Completed s been s should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has death? s certificate has rector, page 2 s performed? 1 🗸 Yes 2 No ✓ Yes 2 26.Place of Death (Check only one) Hospital or Attending Physiciau: 25. Was case referred to medical Division of Vital Be Other₄ examiner? Nursing Home 5 Residence 6 Other: 2 PER/Outpatient 3 DOA Inpatient this 9 No 1 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Jan 30, 2008 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Police involved shooting Certification: 1200 hrs n 24 hours after death. te Funeral Director: A detely filled in by the fu Natural 1 Yes 2 ✔ No Pending 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) 2300 East Northern Parkway , Baltimore , MD determined (Specify) Parking Lot 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 31, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Carol Allan, MD 31. Date filed (Month, Day, Year) 32. Rajistrar's Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

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2008

FEB 0

ORIĞINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 45 AM DONALD HAWKINS 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner N/A bey land enera If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday, **Funeral** Months Days Hours 1□ M 2□ F 43 Director 3180 212 88 OCT.15,1964 MD Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at N/A BALTIMORE 1√ Yes 2 No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21230 USA 2408 MARBOURNE AVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimóre, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry BALTIMORE CITY PUBLIC Elementary/Secondary (0-12) College (1-4or 5+) JANITOR SCHOOL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MINNIE RICKS LEE HAWKINS 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2408 MARBOURNE BALTO, MD. 21230 LARRY HAWKINS (brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Green Mount crematory of other place) FEB. 9,2008 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State BALTO, MD. 4 □ Donation 5 □ Other (Specify) ature of Funeral Service Licensee 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** E2515 /Medical Due to (or as a consequence of): **Examiner** Yneumon Sequentially list conditions, if any, leading to immediate cause. Enter of any, ig Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): and Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown n signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 TYes 1-Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Mann∍ of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 1 V atural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

7

State

31. Date filed (Month, Day,

FEB 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

2008

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Ahuruezeama Imo State of Maryland / Department of Health and Mental Hygiene 2008 03364 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day February 4, 2008 **Medical Examiner** 2030 hrs Ahuruezeama Imo 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Northwest Hospital Randallstown **Baltimore County** 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Director 217-55-7865 3/19/1946 Country)NIGERIA 1X M 2 F 61 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f shov 1 Yes 2 X No or items 23a or 28a-f shown must be notified at once. Baltimore Randallstown more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3803 Cassandra Road 211.33 NIGERIA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc 1 Never Married 2 XMarried Nigerian 2X No Yes 3 Widowed Divorced If Yes, Give Year d other than "natural", the Medical Examiner 1 Yes 2 X No specify: Specify: \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4+ Correctional Officer Baltimore City Jail and Mental Hygiene. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) ent of Health and Mental Hy int: If item 27 is marked of r other traumatic event, the Walter Imo-Nwakuba Nwakolanwayi Onukwue Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3803 Cassandra Road, Randallstown, MD 21133 Ezennia Imo/Wife 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 X Removal from State permit. Page:
Department o
Imporant: I Family Cemetery 2**-**14-08 Lagos, Nigeria Donation 5 Other Specify 22. Name and Address of Facility 21 Signature of Funeral Service License Wylie Funeral Home P.A. of Baltimore Co. 9200 Liberty Road, Randallstown, MD 21133 **Physician** Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and /Medical a. Multiple Injuries Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical physician the burial -UNPENDED AMENDED Box 68760. IF FEMALE: 23c, If yes, outcome of pregnancy 23d. Date of deliven 23b. Was decedent pregnant in the icate has been signed by the attending page 2 should be detached for use as it Live birth 3 Ectopic pregnancy Year Fetal death Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? 1 🗸 Yes 25. Was case referred to medical director. 26. Place of Death (Check only one) Be Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 1 Yes 28a. Date of Injury After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Feb 4, 2008 Pedestrian struck by auto 1 Natural 1946 hrs Pending Yes 2 V No the 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) Offut Rd at Meadow Heights Rd, Randallstown, Md within 24 hours at To the Funeral I determined (Specify) Local Street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 5, 2008 4 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) ©
2. Registrar's Signature State Registra ORIGINAL

08-01015

State of Maryland / Department of Health and Mental Hygiene

2008 03365

		- For State	Certifi	cate of Dea	th	,	Reg	No			
Physicia	_	Decedent's Name (First, Middle,Last)				1	2. Date of Death		3. Time of Death		
ledical Exami		Ralph Leon Jefferso	n				Month February 1,	Day Year 2008	1206 hrs		
		4a. Facility Name (if not institution, give stree	and number)	4b. City	Town, or Loc	cation of Death		4c. County of Dea			
		Prince George's Hospital Cente	r	Che	verly			Prince Georg	je's		
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b			If Under 24Hrs.	8. Date of Birth		irthplace (State or Foreign country)		
Director		214-32-8544 1XM 2	F	72 Yrs. Mon	ths Days	Hours Min.	03/09/3		shington, DC		
	ŀ	Usual Residence of Decedent		_1							
any		10a. State 10b. County	10c. City, Tow	vn or Location					10d. Inside City Limits		
nd show	٦	MD Prince Geo	rges Glen	arden, M	D 2074	6			1 XYes 2 No		
Aaryland 28a-f show any I at once.	둟	10e. Street and Number		10f. Z	ip Code		100	g. Citizen of What Co	untry?		
the N	Director	2912 Brightseat Road	#103	20	706		١,	JSA			
death with the Maryland or items 23a or 28a-f sho must be notified at once.		11. Marital Status 12. V	Vas Decedent Ever in U.S.	13. Was Dece	dent of Hispai	nic Origin? (Spe	ecify Yes or No-	14. Race - Ame	erican Indian, Black,		
leath r iten	Funeral	1 Never Married 2 Married	rmed Forces? Yes 2X No	If Yes, spe	cify Cuban, M	Mexican, Puerto F	Rican, etc.)	White, etc.			
uffer of	by F	3 Widowed 4 X Divorced If Yes,		1 Yes	2 X No s	specify:		Specify: Bla	ick		
ours a		15. Decedent's Education (Specify only high	nest grade completed) 16	a. Decedent's Usu				16b. Kind of Busines	s/Industry		
72 h	Completed	Elementary/Secondary (0-12) C	ollege (1-4 or 5+)	during most of w	orking life. Di	O NOT use retire	3 (1)				
5-0036 led within 7 Hygiene I other than	립	12th	M	laintenan	ce			Private			
5-0 Hygi Tothe		17. Father's Name (First, Middle, Last)			18.	.Mother's Name	(First, Middle, M	aiden Surname)			
21215-0036 Juld be filed within 73 Mental Hygiene marked other than ic event, the Medical	Be	Willis Randolph Jef 19a. Informant's Name/Relationship (Type, P	ferson			Bernice					
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	_			-				per, City or Town, Sta	,		
MD nd 2 sho alth and m 27 is		Lorraine Mae Smith/E		8425 Ham			Glenarde Date	en, MD 207 20c. Location - City	06		
ore, s 1 a of He of He		1 X Burial 2 Cremation 3 Re		natory or other place		itery,	Date	200. Location - Oity	or rown, state		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Health and Mental Hygiene tant: If item 27 is marked other than ' or other traumatic event, the Medical		4 Donation 5 Other Specify:	Harm	nony Memo	rial P	ark 02-	08-2008	Landover,	MD		
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other thinjury or other traumatic event, the Med		21 Signature of Funeral Service Licensee		22. Name a	nd Address of				Home of MD		
			CRAY	4308	<u>Suitla</u>	ınd Road	, Suitla	and, MD			
Physician. 'Medical		23a. Part I. Enter the disease, or complication failure. List only one cause on each line		not enter the mod	e of dying, su	ich as cardiac or	respiratory arre	st, shock, or heart	Approximate Interval Between Onset and		
kaminer			ple Injuries						Death		
		or condition resulting in death) Due to	(or as a consequence of):								
	P	Sequentially list conditions, if any, leading to immediate Due to	(or as a consequence of):								
	틭	cause. Enter Underlying Cause									
- W - ₹	Examiner										
760, cate be executed physician and the burial - transit											
O, be e: sician	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deliv									
5 ta (g'al	١	23b. Was decedent pregnant in the	. If yes, outcome of pregnand Live birth		th 3	Ectopic pregnar	ncv	23d. Date of deliv	ery Day Year		
Box 68's death certification attending	cian	past 12 months?	Pregnant at time of death					1	Du,		
BO) e deatl the att	·75	1 Yes 2 No 9 Unknown g	Unknown								
b.O. that the ned by t	/ Phy	Part II. Other significant conditions contr	buting to death but not resul	Iting in the underly	ng cause give	en in Part I.			to the cause of death?		
, P.O. ires that the signed by	d b						1 Yes	2 🗸 No 3 P	robably 4 Unknown		
ords, w requir	턀						24a. Was a		autopsy findings available o completion of cause of		
E law te has ge 2 sl	Completed	-		· · ·			perform 1 ✓ Yes 2	med? death	?		
tal Rectian: The		25. Was case referred to medical	<u></u>		26.Place of	of Death (Check of			763 2 16		
of Vital Records, g. Physician: The law requir citer this certificate has been s neral director, page 2 should	Be	examiner? Hospita	1:1 Inpatient 2 V ER	VOutpatient 3		thor:	r1	Residence 6 Ot	her:		
n of \ding Phy.	<u>۲</u>	27. Manner of Death 23	Ba. Date of Injury 28	b. Time of Injury	28c. Injury			ow injury occurred			
onding ath.	道	Feliding	eb 1, 2008 11	121 hrs	1 Yes	s 2 🗸 No	Pedestrian s	truck by auto			
Division tal or Attendir rs after death. al Director: A	ica	2 Accident Investigation 2	8e. Place of Injury - At home	e, farm, street, facto	ory, office buil	ilding, etc.			Rural Route Number, City		
Division pital or Attent ours after death eral Director:	Certification:	Galdido Grand Hat Bo	Specify) Major Road /	Highway			or Town, St 133 Capitol He	ate) eights Boulevard, (Capitol Heights, MD		
Hosp 24 hou Funer		00 - 0 - 415 - 4	the best of my knowledge,	death occurred at	the time, date	e and place, and	due to the cause	e(s) and manner as s	tated.		
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	one) 2 Medical Examiner: On the	e basis of examination and/onanner stated.	or investigation, in	my opinion, d	death occurred a	t the time, date a	and place, and due to	the cause(s)		
F N F 8	Re	29b. Signature and title of certifier	iaillei stateu.		29c. License r	number		29d. Date signed (/	Month, Day, Year)		
		Quiet?			O.C.M.	l.E.		February 2, 20	08		
0		30. Name and address of person who comple	eted cause of death (Item 23	a)							
7				1 Penn Street	, Baltimore	e, MD 21201					
		31. Date filed (Month, Day, Year)	32. Registrar's Signature	A. W	R						
Regis	ırar	FFR 0 7 2008	Margaret St.	poorte			0013E				
	004		-				OCME				

Funeral

Director

28a-f show

23a or

death with the Maryland

must be notified 10e. Street and Number 10f. Zip Code 21229 Funeral 4919 Frederick Avenue Apt. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XXNo Specify. þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teacher's Aide 12th grade 17. Father's Name (First, Middle, Last) Be Willie Hancock 19a. Informant's Name/Relationship (Type. Print) Linwood Jones/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Western Star Cemetery 0/08 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fugeral Service Licensee ari Immediate Cause (Find disease or condition resulting in death) MYOCArdIAC Due to (or all a consequence of): Atheroscle 10 So Sequentially list conditions, if any leading Limited late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 24a. Was an 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 → Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ္ 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number D047529 Atthorn

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 03366 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Year Mable Alice Jones Feb.1, 2008 1336 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 8. Date of Birth

(Month, Day, Year)

ne 4,1936 4919 Frederick Avenue Baltimore Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 216-34-4766 1 ☐ M 2 🔀 F Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Maryland N/A Baltimore 1 TXYes 2 □ No Director 10g. Citizen of What Country? USA 14. Race · American Indian Black White etc. Specify: Black 16b. Kind of Business/Industry Baltimore City Public Schools 18. Mother's Name (First, Middle, Maiden Surname) Edna Virginia Allen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 1208 Daniels Avenue Baltimore, Maryland 20c. Location - City or Town, State Catonsville, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisteerstown Rd Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 2 \ N Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. BAST ST BONT IND 21223 R. Juscon MD 1940

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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Des Ca

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2008 12:10 P. M Edward Jackson Jr. Feb. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore ManorCare-Woodbridge Valley Catonsville If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Pay, Year) 3-06-1921 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 214-16-7392 1 M 2 □ F 86 MD. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10a. State r 28a-f show notified at 10b. County 1 X Yes 2 □ No MD n/a Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with to ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 2 ary or other traumatic event, the Medical Examiner must be not or the traumatic event, the Medical Examiner must be not or the traumatic event. 4215 Flowerton Road 21229 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Specify: African-American 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) US Public Health Services Elementary/Secondary (0-12) 6th College (1-4or 5+) Nursing Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Jackson Sr. Margaret Jackson ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sherry Jackson/ Daughter 4215 Flowerton Road, Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If its any injury or o N Burial 2 □ Cremation 3 □ Removal from State Garrison Forest Veterans 2-12-08 Owings Mills, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Wile Funeral Home P.A of Baltimore Co. Signature of Funeral Service Licensee 9200 Liberty Road, Randallstown, MD 21133 randon Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ALZHEIMER'S **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and ker for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
, 1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) I□Yes 2□No 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 1 Natural (Month, Day Year) Injury To the Hospina. within 24 hours efter death.

To the Funeral Director: After and the funeral of the funeral and the funeral an 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0059107 12-06-2008 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REISTERSTOWN MD 21136 210 BUSINESS CANTER DRIVE 2. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

FEB 0 7 2008

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

31. Date filed (Month, Day, Year) State

(Check only one)

Wesley

29b. Signature and title of certifier

Msu

Registrar

and manner stated

RES-000

29d. Date signed (Month. Dav. Year)

Mass 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastein Avenue, Baltimore, MD, 21224

3. Registrar's Signature

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It, Ivial ylaflu z 1 z 13-0030	s 1 and 2 should be filed within 72 hours after death with the Maryland	in reath and wentar hygene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

			1 - State Registrar	Ce	rtificate of	Death	Reg	. No. 2008	03369
	Physicia	an	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic		EugeNNA Kulacki					31 2008	
	Examin	er	4a. Facility Name (If not institution, give street and number)			r Location of Death		4c. County of Deat	hodran
			5. Social Security Number 6. Sex 7. Age (In yrs	s. last birthday,		If Under 24 Hrs.	8. Date of Birth	O Dist	
	Funeral Director		400-05-9706 Usual Residence of Decedent	Yrs.	Months Days	Hours Min.	(Month, Day, Y	'ear) Co	hplace (State or Foreign untry) ntucky
	land t			City, Town or L	ocation				10d. Inside City Limits
	he Mary 8a-f sho otified a	Director		seda1e	T				1 □Yes 2 ^K No
	with th	Dire	10e. Street and Number		10f. Zip Code		10g	g. Citizen of What Co	untry?
	s 23a	eral	820 Rosedale Ave.	11.0	21237	liana di Origina (Con	aif. Van aa Na	USA 14. Race - Ame	rices Indian
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in the Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	J.G. 13.	If Yes, specity Cubi	lispanic Origin? (Spe an, Mexican, Puerto Specify:	Rican, etc.)	Black, White	
2-0	72 ho natur lical (Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occup	ation	16	6b. Kind of Business/	Industry
21	thin 7	nple	Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retired	during most of worki d)			
21	filed withi Hygiene. Ather than	Cor	12	Sec	retary			Energy Com	ipany
pu	be fill	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		aiden Surname)	
3	should be fand Mental Bs marked of	T _o	Burt Embry	401-14-11					
Maryland	d 2 sho th and 7 is ma trauma		19a. Informant's Name/Relationship (Type. Print)					City or Town, State, 2	ap Coae)
	Health Health tem 27 I		Tina Stuller/Grandaughter 20a. Method of Disposition 20b.		Rosedale cosition (Name of ematory or other place			4D 21237 Oc. Location - City or	Town, State
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once,		TABURA 2 Demation 3 nemoval from state			1			
#	permit. P Departme Importan any injur.		4 ☐ Donation 5 ☐ Other (Specify) Dt 21. Signature of Funeral Service Licensee	ılaney 2	Valley 22. Name and Addre	02/02	·	Timonium Funeral Ho	MD
B	permit. Departri Importa any inju		Berin G. W. O.			r Rd. Not			ome inc.
			23a. Part1. Enter the disease, or complications that caused the dea						Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	Faston	A .				Onset and Death
1	/Medical		resulting in death) a. Due to (or as a conse		<u> </u>				, Feb
	Examiner		Sequentially list conditions b. U.F.I. Syd!						Raza
ы	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that bill list as a consecutive of the conditions of the condition						9
	ocuter nd transi	Examiner	trial finitaled events						Page
90,	e exe sian a urial-		Due to (or as a conse	equence of):					
68760,	ortificate be executed ing physician and as the burial-transit	Medical	d						
	ding page as	_	IF FEMALE: 23c. If yes, outcome pf preg	inanov					
.O. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician,	23b. Was decedent pregnant in the past 12 months? 1	tal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of del Month	Day Year
۳,	s that ned b		Part II. Other significant conditions contributing to death but not re	sulting in the	underlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
or Vital Records,	w require been sig should b	Completed by	Vysphyn				1 ☐ Yes	2 □ No 3 □ Pr	obably 4 ☐Unknown
ပ္တ	aw requisited sections and sections are sections as the section of	plet	CAS				24a. Was an	24b. Were au	utopsy findings available
æ	sician: The law s certificate has b irector, page 2 s	lmo	So in Donata				autopsy performe	ed? death? □ 1 □ Yes	completion of cause of 2 □ No
ta		BeC	25. Was case referred to medical			26. Place of Death	(Check only one)		20110
<u>r</u> <		ToE	examiner? 1 Yes 2 Hospital: 1 Inpatient 2	☐ ER/Outpatie	ent 3 DOA Oth	ner: 4 Nursing Ho	me 5 Residen	ice 6 Other (Spe	cify)
o uo	Jing After fune		27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year)	28b. Time Injury	Wor	ry at rk? Yes 2 ☐ No	28d. Describe how	v injury occurred	
Division	To the Hospital or Attend within 24 hours after death. To the Funeral Director; /	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At building, etc. (Spec	home, farm, s	treet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ri State)	ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in the	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my king the properties of examiners of examiners and manner stated.	nowledge, dea nation and/or i	ath occurred at the ti investigation, in my	me, date and place, opinion, death occur	and due to the cau red at the time, dat	use(s) and manner as te and place, and du	s stated. e to the cause(s)
	To the Comp	Me	29b. Signature and title of certifier		29c. Licens	se number	296	d. Date signed (Mont	th, Day, Year)
	7		Wand Klox mo		P	31295		2/11	08
	`		30. Name and address of person who completed cause of death (Ite						
0)		Wendy Klosz 670) N		13 St S	out 4202	- 70ws	unk	21306
	Sta Registi		31. Date filed (Month, Day, Year) September 1 2008 32. Registrar's Sig	nature	and I				

			For State Registrar	State of Man	yland /	•	ent of Hea ate of De			ene 008	03370
. 3	Physicia	_	1. Decedent's Name (First, Middle, Last,	H.	Ku	RTZ	5,	r.	2. Date of Death Month		
	/Medic Examin	- 31	4a. Facility Name (If not institution, give	street and number)	POA	4b. Ci	y, Town, or Loc		CIS-VIII-7	4c. County of De	
	Funeral Director		5. Social Security Number 6. Se	ZM 2□F	In yrs. last	birthday) If Und Yrs. Month		Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day, Mar. 13	Year) 9. B	irthplace (State or Foreign Country) Mary Land
D).	yland		Usual Residence of Decedent 10a. State 10b. County			own or Location			riaL• IJ	, 1701	10d. Inside City Limits
	the Mar 28a-f et	Director	MD Anne Ar	undel		10f	Arnold Zip Code		10	g. Citizen of What	1 ☐ Yes 2 No
	ath with	ral Dli	1210 Summerwood Co			, , , ,	210	12		United	States
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: if Item 27 is marked other then "natural; or Iteme 23e or 28e-f show appringing or other traumatic avent, if a Medical Examination the notified at ODGE.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:	er in U.S.	If Yes, s	pecify Cuban, M	nic Origin? (Spe fexican, Puerto pecify:	ecify Yes or No- Rican, etc.)	Black, Wi	nerican Indian, hite, etc. White
Baltimore, Maryland 21215-0036	ithin 72 ho ne. nen "netu	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation le completed) College (1-4or 5+)	16	6a. Decedent's U (Give kind of life. DO NO	work done durin	ng most of worki	ng 1	6b. Kind of Busines	ss/industry
d 21	filed w I Hygier other th	Be Cor	11. 17. Father's Name (First, Middle, Last)			Pai	nter 18.		(First, Middle, M	Home Impr daiden Sumame)	ovement
rylar	should be and Mental marked o	ToB	Clarence Kurtz 19a. Informant's Name/Relationship (7)	una Print)		Ob Mailing Addr	oss (Stroot and	Anna H		City or Town, State	Zin Codo)
, Ma	and 2 sland 2 sland 2 sland 2 sland 27 is retraur		Robin Kalvzienski	- Daughter	: 1	.210 Sum	nerwood			MD 21012	
nore	Pages 1 nent of He ant: If Iten ary or oth	1	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 6 4 ☐ Donation 5 ☐ Other (Specify,		J 1 _	of Disposition (for Arthrope	lame of other place)	1		Oc. Location - City	
Baltir	permit. P Departme Importen any injur		21. Sometime Eurocal Serves Licens		J-G				b ro se Fu	Odenton, neral Hom rbutus, M	e, Inc.
	Ė		23a Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the ine cause on each line.		o not enter the m	ode of dying, so				Approximate Interval Between Ogset and Death
-37	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	aDue to (or as a c		ce of):	•				1 Cyers
	Examiner	ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a c	orizequorio	ou of):					
8760,	cate be executed oblysicien and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a c	consequenc	ce of):					
O. Box 68	ath certifi tending I or use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 (4□Pregnant at tin 9□Unknown	Fetal dea	ath 3□Ectopi	pregnancy (specify)			23d. Date of Month	delivery Day Year
rds, P	quires that the de n signed by the a uld be detached t	þ	Part II. Other significant conditions co	ntributing to death but	not resultin	g in the underlyin	g cause given in	n Part I.	23e. Did tob 1 ☐ Ye		e to the cause of death? Probably 4 Unknown
Vital Records,	The law requir sete has been si page 2 should	Completed							24a. Was ar autopsy perform 1 Yes 2	24b. Were prior death	
Vita	rsiclan: The s certificete director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient	2 □ FB/	Outpatient 3	1 04		Check only one	nce 6 Other (S	inecity)
Division of	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2		27. Manny of Death 1 atural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y		b. Time of Injury	28c. Injury at Work?		28d. Describe ho		pacity)
Divis	s after death	Certification:	3 Surcide 6 Could not be determined	28e. Place of Injury building, etc.	/ - At home (Specity)	, farm, street, fac	tory, office		28f. Location (Str City or Town	reet and Number or , State)	Rural Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone)	ysician: To the best of iner: On the basis of eand manner state	xamination	dge, death occur and/or investigat	ed at the time, o	date and place, on, death occur	and due to the ca red at the time, da	use(s) and manner ate and place, and o	as stated. due to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier	44.	les	W	29c. License nu	umber 2/2/	29	9d. Date signed (Mi	onth, Day, Year)
F	١		30. Name and address of person who	completed cause of dea	ith (Item 23	Sa) (Type, Print)	1/	100		110000	7 47
	Sta	ate	31. Date filed (Month, Day Year)	2000 32. Registrar	s Signature	2748/125/	MCHNA	1/111	RSVILLE.	MIV Ela	408
- 3	Regist	rar	LED U 7	2000	and the state of t	to fre	A. C.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year February 4, Gilbert Lee Lester 8:15 A 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Joseph Ritchey Hospice Baltimore 8. Date of Birth (Month, Day, Year) Feb. 20, 1928 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) Days Yrs. 79 213-26-0873 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Baltimore Lansdowne 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 125 Clyde Avenue 21227 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Food Service 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Elmer Lester Emma Rebecca Leighter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7987 Scott's Manor Court, Glen Burnie, MD 21061 Mary Koch - Daughter 20b. Place of Disposition (Name of ncemetery crematory of other place) West Arundel Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 XCremation 3 Removal from State Odenton, MD 2-7-2008 4 Donation 5 ☐ Other (Specify) Crematory 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service License 2719 Hammonds Fry Rd., Lansdowne, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) rement Years Due to (or as | consequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown -obstructive 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 Yes 2 No Hospital: Spice 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner 68760, Records, Vital 9

Physician

/Medical

Examiner

Funeral Director

Be Completed by

Funeral

Director

2 should be filed within 72 hours after death with the Maryland i and Mental Hygiene.
Is marked other than "natural" or Isane 220 Anne 120 Anne 120 Anne 200
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

/Medical

Physician/Medical Examiner

Be Completed by

Medical Certification: To

29a. Certifier (Check only one)

29b. Signature and title of certifier

MD

150

31. Date filed (Month, Day, Year)

for use as

funeral director,

filled in by

completely

24 hours after death Pruneral Director:

within 2.

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Hospital or Attending Division

Silbert

HXI

State

Registrar

and manner stated.

Haspice

32. Pagistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Richey

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the dead of the pasts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

838 N. EutawSt Bultimore MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear Month **Physician** Aura G. Mazariegos 5:25 A[™] 6, 2008 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Randallstown Randallstown Baltimore 8. Date of Birth (Month, Day, Year) April 10,1930 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** 1□ M 💥 🗆 F 578-64-0283 77 Guatemala Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No "natural", or items 23a or 28a-f shedical Examiner must be notified Director Columbia Maryland Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10547 Twin Rivers Road Apt. B2 21044 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify:Guatemalan 1X Yes 2 □ No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Medical (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Hospital <u>Nurse</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Aurelio A. Mazariegos Hercilia Godoy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jon Sheffer, Caregiver Columbia, MD 21044 <u>10547 Twin Rivers Road Apt.B2</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 02/06/08 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licenses Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition and isease or condition and isease or condition and the cause of the ca Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner oronani Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consult Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) attending physician for use as the burial Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 performed? (es 2 No this certificate Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Tes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completely filled in by the funeral Certification: the Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number signature and titl 29d. Date signed (Month, Day, Year) 29b.

State

Registrar DHMH 17 Rev 1/2001 30. Name and address of pe

31. Date filed (Month, Day,

Avenue, Baltimore, MD21228

of death (Item 23a) (Type, Print)

32, Registrar's Signature

non who completed cause of deam.

F. I - Sayed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh 98/6 2-27-08 vt. State of Maryland / Department of Health and Mental Hygiene 0 0 0

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** 200808.20Am Mislak EB3 Catherine 72 Mary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Agnes If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of **20.** (Month, **20.** Year) 0ct. **20.** 1932 7. Age (In yrs, last birthday) 9 Birtholace (State or Foreign **Funeral** Months Days Hours Min. 1 M 2 KF Maryland 75 Director 218-28-0086 Usuat Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ul Hygiene. other than "natural", or iteme 23a or 28a-f ehow vent, the Madical Examinar must be notified at Baltimore Maryland Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1606 Kirkwood Road 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt Department of Heelth and Mental Hy Importent: If Item 27 Is marked oth any finjury or other traumatic event 2018. Be Keelan Raymond Charles Clampitt Marion 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1606 Kirkwood Rd., Baltimore, MD 21229 Walter J. Mislak (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 2/6/08 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part. — I fer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician EXACBERATION 3 WEEKS TCUTE COPD /Medical Due to (or as a consequence of): Examiner ESPIRATOR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (ur as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): led by the attending physicien detached for use as the buria Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should be KYPHOSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed PARKINSON'S DISEA 24a. Was an autopsy performed? 1 ☐ Yes 2 € No 24b. Were autopsy findings available prior to completion of cause of death? certificate hes 1 Tes 2 No or Attending Physician: : After this certification funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death

1 Matural
2 Accident 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending death. investigation 1 □ Yes 2 □ No completely filled in by the within 24 hours efter deat To the Funeral Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) FEB 02 2008 STAFF PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANDRA BOMMA MD STAGNES HOSPITAL, 900 CATON AVE, BALTIMORE, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FEB 0 A PERSON

MARY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 1- State Registrar Amend #18, perFH, g876, 2/12/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Daniel G. Miller, Sr. 02-03-2008 5:45 p ^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1516 Cabin Rd Aberdeen, MD Harford If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F Director 50 04-04-1957 217-74-6234 Mary Tand Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or itams 23a or 28a-f shov It a Medical Exaction must be notified at 1 Yes 2 No Director Maryland Harford Aberdeen 10e. Street and Number 10f Zip Code 10g, Citizen of What Country? 1516 Cabin Rd 21001 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Detective Baltimore Co. Police 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ould be Gene Miller Donna Simmons Dorothy Waters ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum once. Maryanna Miller (Wife) 1516 Cabin Rd Aberdeen, MD 21001 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 02-05-2008 Baltimore, Maryland 4 Donation 5 Other (Specify) Bayview Crematory 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air lane. MacPhail Rd Bel Air, MD 21014 Inc. 610 W. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Tocenge Physician lpro canal 15 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dire to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 2 Fetal death 3 DEctopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the e 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2€No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 1 ☐ Yes 2 No 1 Yes : After this certifice funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one, Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending 1. Natural 5 Pending investigation death. 1 Yes 2 No Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after or To the Funaral Direct 4 Homicide pelli 29a. Certifiei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. pletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number S. Pasqueras 0053720 February 56 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) wp S. Pergueratimo, God S. Africaso pro 4100, 210014 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

> 2. Date of Death Month

DHMH 17 Rev 1/2001

Registrar

2008

State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician 02 - 03 - 200806:25 a^M Herman Leslie Montague /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner P.G. Hospital Cheverly Prince Georges County If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 XM 2 □ F 66 Yrs. Director 03-10-1941 577-54-9290 Washington, DC Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 le marked other then "natural", or Items 23a or 28a-f ehow treumatic event, the Medical Examinar must be notified at Prince Georges Forestville, MD 1 XYes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1417 Shady Glen Drive 20747 death permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hyglene. Important: If item 27 ie marked other then "natural". cr. ii... env injury or other treurmatic exercise. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Solid Waste Crane Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Gladys Lewis George Montague 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1417 Shady Glen Dr., Forestville, MD 20747 Shirley Montague/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cem. 2-8-2008 Brentwood, MD 22. Name and Address of Facility Marshall's Funeral HOme of MD 21. Signature of Funeral Service Licensee 4308 Suitland Road, Suitland, MD 20746 D. ORA) 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Septicemia /Medical Due to (or as a consequence of). Examiner Endstage Renal Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner law requires that the death certificate be executed burial-transit Chronic Respiratory Failure led by the attending physicien and detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 certificate has been signe frector, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2 🔯 No 2 XNo 1 Yes 1 Tyes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Certification: To 1 Nnpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospitel or Attending 1 XNatural 2 ☐ Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1x Certifying Physician: To the bast of my knowledge death occurred at the time. Jake and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai completely (Check only within 2 29b. Signature and title of certifier tenn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MID CUMBERBATCH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 A Second 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-00816 State of Maryland / Department of Health and Mental Hygiene Garrett McMillion, Jr. Certificate of Death Reg. No 1- For State Time of Death Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month 1716 hrs January 29, 2008 Medical Examiner McMillion, Jr. F. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** N/A5013 Ready Avenue 9. Birthplace (State or Foreign Washington If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Country) D.C. July 2, 1945 62 Director 226-58-3408 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State any 1 X Yes 2 No Baltimore N/A or 28a-f show MD items 23a or 28a-f shoust be notified at once, 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 21212 USA 5013 Ready Ave. Apt. B 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 X No Yes Specify: White 4 X Divorced If Yes, Give Year Yes 2 X No specify: Pages 1 and 2 should be filed within 72 hours after 16b. Kind of Business/Industry þ 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) the Medical than MD 21215-0036 Hospitali<u>ty</u> N/AManager of Health and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Melvina Hamblin Be Garrett Frederick McMillion 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD 21093 Timoinum, 11933 Thurloe Dr. Peter W. Ireland, Sr./Friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, trau 20a. Method of Disposition Feb. 4, Metro Crematory Baltimore, Burial 2 X Cremation 3 Removal from State Baltimore, MD 2008 pe mit Page Department In portant; Other Specify: Donation Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093 Bryan W. Clary Approximate Interva e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear 23a. Part I. Exer the disease, or complications that caus Between Onset and Physician failure List only one cause on each line. Death /Medical Atherosclerotic cardiovascular disease Immediate Cause IF hal disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed and Physician/Medical UNPENDED AMENDED , PII, 27, perME, C876, 2/29/08 TI tending physician a 23d Date of delivery The law requires that the death certificate be Box 68760. 23c. If yes, outcome of pregnancy IF FEMALE: Year Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown þ Diabetes, morbid obesity 24b. Were autopsy findings available 24a. Was an Completed prior to completion of cause of been autopsy death? performed? certificate has 2 No ✓ Yes 2 No 1 1 26,Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: of Vital director Be Other: Nursing Home 5 Residence 6 Other: Scene examiner? DOA Inpatient ER/Outpatient 3 this 1 V Yes No 28d. Describe how injury occurred 28c. Injury at Work? funeral 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After Certification: 1X Yes 2 No Natural Division Pending Director: 28f. Location (Street and Number or Rural Route Number, City 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Could not be 24 hours after 3 Suicide determined 4 To the Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DOME January 30, 2008 O.C.M.E. TM me and address of person who completed cause of death (Item 23a)

31. Date filed (Menity Day, Year) State Registra

Theodore M. King, Jr., MD.

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner 2. Registrar's Signature

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2

2. Date of Death

Month

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1XX es 2 No

1:00 A M

Year

1942 Maryland

14. Bace - American Indian. Black, White, etc.

Specify: White

16b. Kind of Business/Industry

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Ho

2008

Month

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

FEBRUARY

performe 2 🕠

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

Year

Motor Oil

2008

4c. County of Death

Year)

or Vital Records, Division

af or Attendation after death filled in by within 24 hours a

To the Funeral I

completely filled 10 State

this funeral

the

Registrar DHMH 17 Rev 1/2001

Be

P

Certification:

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of cartifier

25. Was case referred to medical examiner?

2 No

5 Pending investigation

6 ☐ Could not be

determined

1 ☐ Yes

27. Mann 1 Death

2 Accident

4 ☐ Homicide

(Check only one)

3 ☐ Suicide

29a, Certifier

Hospital:

1 Inpatient

(Month, Day

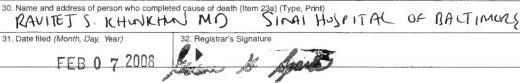
W

28a. Date of Injury

1 - For State Registrar

Physician

1. Decedent's Name (First, Middle, Last)



2 ER/Outpatient 3 DOA

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Ddd63430

1 ☐ Yes 2 ☐ No

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

			For 1 _ State	State of Ma	ryland	-				ntal Hy	giene		
			Registrar 1. Decedent's Name (First, Middle, L	ast)		Cen	ificate of I	Death		Date of Dea	Reg. No.	2001	3 3 8 1 3. Time of Death
	Physicia /Medic		JOSEPH F.	,						Month EBRU		4 200	a
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	Funeral			Sex 7. Age	(In yrs. las		If Under 1 Year Months Days	If Under Hours	24 Hrs. 8	Date of Birt	h Voar	I o B	irthplace (State or Foreign
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land	at		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Fown or Loca	tion						10d. Inside City Limits
e Man	a-f sh tifled	Director	MD BAI	TIMORE	MID	DLE	IVER						1, ∐Yes 2 MiNo
with th	a or 28 be no	Dire	10e. Street and Number 307 FARWIND DE	RIVE APT	1C		10f. Zip Code 2122	^			10g. Citiz	en of What C	Country?
death	ms 23	Funeral	11. Marital Status	12. Was Decedent E		13. W	as Decedent of H		igin? (Specify	Yes or No-	. 1		nerican Indian,
5-0036 72 hours after death with the Maryland	if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fui	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	0 7 T T T T T T T T T T T T T T T T T T T	1	res, specity Cuba ⊒Yes 2√2√No	an, Mexicar Specify:		an, etc.)		Black, Wh Specify: WH	
Maryland 21215-0036	natural Ical Ex	ted k	15. Decedent's (Specify only highest g	Year or Dates: V		16a. Decede	nt's Usual Occup	ation	at of working		16b. Kin	nd of Busines	s/Industry
121	han "r e Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	+)		nd of work done of NOT use retired RPLANE				M A	RTIN'	c
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//ar)	rauma	ė į	19a. Informant's Name/Relationship		I		Address (Street				-		
re, r	Healtl tem 27 other t		PAULINE FILLMO 20a. Method of Disposition	RE/SISTER	20b. Plac	e of Disposi	WOODRI		RD BA.		<u>.</u>		r Town, State
SSaw altimore mit. Pages 1	int: If I		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special	Removal from State		netery, crema KWOOD	tory or other plac		2/7/0	8	BAL	TIMOR	RE, MD
SSaw. Baltimore,	popuration of Health a Important: If Item 27 is any injury or other training once.		21. Signature of Fundamental Society ice Lice		'								NERAL HOME
(9)			23a, Part1, Enter the disease, or co	mplications that caused	the death		11 CHE					E, ML	21237 Approximate
PF	hysician	0 1	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	7	1	1.	o out		die a	opilatory a	1031,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Chronic Due to (or as a	_		c had love	nary	(11) 6	[35			years
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08 38760 , cate be executed	physician and the burial-transit		resulting in death) Last	Due to (or as a	consequer	nce of):							
8760 cate be		edical		d									
		n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p							2:	3d. Date of d	elivery
NOUGH AH	he atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2 4□Pregnant at t 9□Unknown			ctopic pregnancy Other <i>(specify)</i>	/				Month	Day Year
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Jor B Phy		n: To	27. Manner of Death	28a. Date of Injury (Month, Day	y 28	8b. Time of Injury	28c. Injun Work		arsing Home 28d.	Describe h			pecify) HODICE
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Divi	within 24 hours after death. To the Funeral Director: A completely filled in by the funeral brack in the function of	Certification:	4 ☐ Homicide determine		ry - At home . <i>(Specify)</i>	e, farm, stree	t, factory, office		28f.	Location (S City or Tox	Street and vn, State)	d Number or i	Rural Route Number,
Div	hours uneral	calC	29a. Certifier 1 Certifying I	Physician: To the best of aminer: On the basis of	f my knowle	edge, death	occurred at the tin	ne, date ar	nd place, and	due to the	cause(s)	and manner	as stated.
the	thin 24	Medical	one) 29b. Signature and fitle of certifier	and manner stat	led.	II allovol lilve	29c. License						nth, Day, Year)
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~	/x		30. Name and address of person wh	o completed cause of de	ath (Item 23	3a) (Type, Pi	int),	, -	Bultin		T 291	wary.	1,200
10			E. Tso MD Riche	32. Registrar	838		itaw S	t	Sultin	nore,	MI	212	-01
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	, etc		Registrar 1. Decedent's Name (First, Middle, Last)		Tillicate of L	Jean	Reg. 2. Date of Death	No.	3. Time of Death			
	Physicia		RUTH ONeill				Month	Day Year	-760			
	/Medic Examin		4a. Facility Name (If not institution, give street and number,		4b. City, Town, or	Location of Death		4c. County of Deat				
,	4	579	7875 Walnut Grove Road		Severn			Anne Aru	ındel			
	Funeral Director		5. Social Security Number 6. Sex 7. All 1 M 2 1 F	ge (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Nov. 21,	ear) Co	hplace (State or Foreign buntry) MD			
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	shov shov	or.	10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 🛣 No			
	the M 28a-f notiff	Director	MD Anne Arunde1 10e. Street and Number	Brooklyn	10f. Zip Code		10a	. Citizen of What Co	ountry?			
	h with	iO le	305 W. Riverview Road		21225			J.S.A.	,			
	death	Funeral	11. Marital Status 12. Was Decedent Armed Forces'	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spen	ecify Yes or No-	14. Race - Ame Black, Whit				
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:	No	1 ☐ Yes 2 No	Specify:	rticali, etc.,	Specify: Wh	·			
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7	within ene. than "	mp	Elementary/Secondary (0-12) College (1-4or	5+) life.	DO NOT use retired) ical Work			Office				
70	filed v Hygie other i	ပိ	17. Father's Name (First, Middle, Last)	CTELI		18. Mother's Name	e (First, Middle, Mai					
yland	lid be fental rked c	To Be	Charles A. Herche			Margare	tha K. Sc	hlicker				
Mary	shou and N s mar	-	19a. Informant's Name/Relationship (Type. Print)		ng Address (Street a				Zip Code)			
χ. Σ	and 2 lealth m 27 I		Mrs. Patricia Renes/ Daugh		Walnut Gr							
saltimore,	ages 1 nt of H If ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State		matory or other place	1 2000	8, 200	c. Location - City or				
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	Physician		Immediate Cause (Final disease or condition	Α.					Onset and Death			
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Š	death certiff e attending id for use as	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome		7e			23d. Date of de	livery			
<u>ه</u>	ne deat the atte	Physician/Me			□Ectopic pregnancy □ Other <i>(specify)</i>			Month	Day Year			
Ţ.	that the		Part II. Other significant conditions contributing to death I	out not resulting in the u	ınderlyi n g cause give	n in Part I.	23e. Did tobac	co use contribute to	the cause of death?			
coras,	The law requires that the tate has been signed by the page 2 should be detache	ed by	Hypertensin for	iphrul	afte	nol	1 ☐ Yes	2No 3 □ P	robably 4 Unknown			
) (၁	law re as bee 2 sho	Completed	disese	V			24a. Was an	24b. Were at	utopsy findings available completion of cause of			
	The ate has page	Som					autopsy performe 1 Yes 2 €		1/			
VII.	iclan: sertific actor,	Be (25. Was case referred to medical examiner?		lou		(Check only one)		- Du Aiden			
5	Physiclan: r this certific ral director,	<u>۲</u>	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpati			4 Nursing Ho	me 5 Residence 28d. Describe how		city) Home			
201	th. the true	tion	1 ■ Natural 5 □ Pending (Month, Da 2 □ Accident investigation		Work	?" /es 2 □ No	20d. Describe now	mjary occurred				
22	r Atter er dea rector by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of in	jury - At home, farm, str tc. <i>(Specify)</i>	reet, factory, office		28f. Location (Stree City or Town, S	et and Number or R	ural Route Number,			
2	oital or urs afte eral Dii											
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death, and the fact death. To the Furental Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) 1	of examination and/or in	nvestigation, in my op	ne, date and place, pinion, death occur	and due to the causered at the time, date	se(s) and manner as e and place, and du	s stated. e to the cause(s)			
7	To t	Σ	29b. Signature and title of certifier Physic	ian -	29c. License	number 7 7	7 -	Date signed (Moni	th, Day, Year) 2008			
A	5		30. Na of purson who completed cause of	death (Item 23a) (Type.	Print)	-	1	-0 - 0	_			
	7	1	Gurmeet S. Sawhney M.D. 3		95.	en Burni	e, MD 210	61				
	Sta			rar's Signature	A Prince of the Paris of the Pa	*						
	Registr	ar	FEB 0 7 2008	13° 1300								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 3, 2008 Year CURTIS LEE POSTON 2218 hrs al Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Prince George's Cheverly Prince George's Hospital Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Director January 7,198 Country) MD 1X M 2 F 26 219-02-6568 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County 1 X Yes 2 No 28a-f shov Temple Hills Prince Georges with the Maryland 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number USA 20748 3103 Good Hope Avenue #507 Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? death 1 X Never Married 2 X No Yes Specify: Black hours after Yes 2 No specify: If Yes, Give Year Widowed 4 Divorced ۵ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) marked other than "natur Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 72 MD 21215-0036 Private I and 2 should be filed within Health and Mental Hygiene. Mover 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Velina Roxanne Harrison James Poston, III 19a. Informant's Name/Relationship (Type, Print) (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9877 Good Luck Road #1, Lanham, MD 20706 item 27 is Velina R. Exum/mother 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, crematory or other place) permit. Pages I Department of H Important: If i 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other Specify 02-11-08 Landover, MD rmony Memorial 22. Name and Address of Facility Marshall's Funeral HOme of MD 4308 Suitland Road, Suitland, Maryland 20748 Approximate Interval t. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **'hysician** Between Onset and ailure. List only one cause on each line Medical Death a. Gunshot Wounds (2) to Chest and Back Immediate Cause (Final disease ∠xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last certificate be executed and Physician/Medical UNPENDED AMENDED Box 68760 ending physuse as the b IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) requires that the death 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ģ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy has . death? ✓ Yes 2 No 1 🗸 Yes 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other, Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 Nursing Home 5 Residence 6 Other this 1 ✓ Yes 28a. Date of Injury To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After i 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After 27. Manner of Death Certification Subject shot Feb 3, 2008 2110 hrs Natural 1 Yes 2 ✔ No 5 Pending 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 Suicide or Town, State) 1200 Cap Center Boulevard, Largo, Md. determined (Specify) Restaurant 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 4, 2008 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State EFR 0 Registrar

State of Maryland / Department of Health and Mental Hygiene Department of Peartment of Death Department of Health and Mental Hygiene Department of Health and Health and Mental Hygiene Department of Health and Mental Hygiene Department of Health and Health and Mental Hygiene Department of Health and Health and Health and Mental Hygiene Department of Health and Health an	
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23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome pt pregnancy 1 Live birth 2 Fetal death 5 Other (specify) Month Day Year	
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24a. Was an autopsy performed? The results of the	cause of
25. Was case referred to medical examiner?	
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	
27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28c. Date of Injury 28c. Injury at Work? 1 Yes 2 No	
To see the content of	mber,
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b of the state of	``
29b. Signature and title of certifier 29c. License number RES 0000 29d. Date signed (Month, Day, Year)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR Wajahath Moh SiNi 9000 FRANKLIN Square DR Baltimore ind 21237	7
State Registrar FEB 0 7 2008 32. Registrar's Signature	

DHMH 17 Rev 1/2001

Physician /Medical Examiner

Funeral Director death with the Maryland

23a or 28a-f show ust be notified at an "natural", or items 23a Medical Examiner must d 2 should be filed within 7, th and Mental Hygiene. 7 is marked other than "n; traumatic event, the

72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

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Physician /Medical Examiner

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To the Hospital or Attendinwithin 24 hours after death.

To the Funeral Director; Aft completely filled in by the fur

8:00 PM Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days 1 □ M 2 😾 F 93 May 19, 1914 | Vermont 080-30-9577 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Linthicum 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 412 Darlene Avenue 21090 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√☐ No Specify: Specify:White 3. Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mikitas Dunducas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joyce Nichols (Daughter) 412 Darlene Ave., Linthicum, MD. 21090 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore Crematory
C Loudon Park 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/4/08 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licenses 3620 Wilkens Ave., Baltimore, MD 21229 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PNEUMONIA DAYS disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of death 9 Unknown 3 ☐ Ectopic pregnancy Month Year 5 Other (specify) 9 ☐ Unknowh 23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ARTERY

DISEASE

MELLITUS

FAILURE

Hospital: 1 Mnpatient 2 ER/Outpatient 3 DOA 28h Time of

28a. Date of Injury (Month, Day Year)

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

autopsv performe

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

BALTIMORE.

29b. Signature and title of certifier M. Mang at 29c. License number

29d. Date signed (Month, Day, Year) 28, 2008 JANUARY

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVENUE MANPREET MANGAT, CATON

31. Date filed (Month, Day, Year)

DIABETES

RENAL

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural 2 Accident

3□ Suicide

29a. Certifier (Check only one)

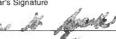
4 ☐ Homicide

32. Registrar's Signature

5 ☐ Pending investigation

6 ☐ Could not be

determined



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician PHYLLIS QUARLES FERMIN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Battmore Battono If Under 1 If Under 24 Hrs. 8. Date of Birth Social Security Numb Age (In vrs. last birthday) Birthplace (State)
 Country) **Funeral** Months Days Hours Min 1 □ M 2 💢 F 08/28/1959 217-54-0314 48 MD Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No SC HORRY MYRTLE BEACH Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 703 BONNIE DRIVE 29588 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No WHITE Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) SALES RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LEVY IRVIN CHARLOTTE DARSCH ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM QUARLES JR / HUSBAND 703 BONNIE DRIVE, MYRTLE BEACH, SC 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State HEBREW YOUNG MENS 02/06/2008 BALTIMORE, MD 4 Donation 5 ☐ Other (Specify) Funeral Service (cens 22. Name and Address of Facility 21. Sign SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, 23a. Part1. Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one can see on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lise as a Tripin) that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed ng physician and as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea:
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month 5 ☐ Other (specify) signed by the a P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, x nknown 1 ☐ Yes 2 No 3 Probably certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2□ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) spital: Inpatient 28a. Date of Injury 1 ☐ Yes ို 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Dahn 1 Natural 2 Accident 28b. Time of spital or Attending Ploous after death.
neral Director: After the filled in by the funera 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours af To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) of a thompse 2401 W. Advided Are Athmore 30. Name and address of purson who completed cause of death (Item 23a) (Type, Print) 7 31. Date filed (M Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

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		•	For State Registrar			Certific	ate of l	Death		Reg. No. 2 ()	08	03	387
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4	Physicia /Medic Examin	al	Robert J. Rosenst 4a. Facility Name (If not institution, giv		-	4b. C	ty, Town, or	r Location of De	Februar		08	12:1	0 A ^M
	, Examini	О.	Oak Crest Retirem	nent			rkvil	le		Balti			
~	Funeral		5. Social Security Number 6. S	Sex 7. Age	(In yrs. last birti	Mont	der 1 Year ns Days	If Under 24 H Hours M	in. (Month, Da	ay, Year)	9. Birthpl Coun	ace (State try)	or Foreign
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	land ow	ŀ	10a. State 10b. County		10c. City, Town	or Location					10	Od. Inside C	ity Limits
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	r dea	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was De If Yes, s	cedent of H pecify Cuba	ispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	D- 14. Rad Blad	e - America ck, White, o		
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7	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, the Medical Examiner must be notified at	Completed	12	1+		ysicia	ın			Medic			
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Robert J. Rosens	**			•		Rural Route Numb Whitefor			Code)	
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ã	Dep any		Buran G. i	velle	J	610 V	V. Mac	Phail F	Rd. Bel A			ic inc	- •
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	/Medical Examiner		resulting in death)	Due to (or as	a consequent e c	of):							
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	ted 1sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence c)).							
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Box	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 □Live birth	pf pregnancy 2 Fetal death	3 □Ectop	cpregnancy	v			ate of delive	ery Day	Year
	e dea he att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown		5 Other		,		IVIC	אוווו	Day	Ieai
P. 0.	hat th d by I		Part II. Other significant conditions	contributing to death b	ut not resulting in	the underlying	ng cause giv	en in Part I.	23e. Did	tobacco use con	tribute to th	ne cause of	death?
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\geq	Physician: r this certifica ral director, I	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatie	ent 2 ☐ ER/Out	tpatient 3□	DOA Oth	ior:	g Home 5□Res		her (Specif	y)	
0	ng Ph ter th neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju		ime of	28c. Injur Wor	ry at rk?	28d. Describe	how injury occu	rred		
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral		29a. Certifier 1 Certifying Pl	hysician: To the best	of my knowledge	death occur	red at the ti	me, date and p	lace, and due to the	e cause(s) and m	anner as s	tated.	
	the Hospital nin 24 hours a the Funeral I npletely filled	Medical		miner: On the basis o and manner sta	f examination and								e(s)
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٠,١	7		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type, Print)			4				
4			Etosha Pixon		D Walt	her B	ud, 1	artville	MD 212	34			
	Sta Registi		31. Date filed (Month, Day, Year)	8 January 18	ar's Signature	seed)		/					

DHMH 17 Rev 1/2001

Dr Robert Rosensteel

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year SR 11:01 A M **Physician** GEORGE RANDAL FEB 02 2000 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MANYLAND MEDICAL CENTER BAUTIMONE UNIVERSITY OF If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Country) 1 X M 2 □ F Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a, State 10b. County show iral", or items 23a or 28a-f shov Examiner must be notified at 1 XYes 2 No Director More 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Unit 308 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or iter 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Specify: ò Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Şecondary (0-12) College (1-4or 5+) Oppers 18. Mother's Name (First, Middle, Maiden Gurname) 17. Father's Name (First, Middle, Last) Be ၉ zeorgianna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) unit 00 Doroth Department of Healt Important: If item 2 any injury or other once. Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 Removal from State 2008 GreenMount Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service, Licensee 22 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the burial IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Vear in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 I Inknown by s been signed by should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2: autopsy performed? 2 ☑ No 2∏No 1 ☐ Yes certificate Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Affer Injury 5 ☐ Pending investigation 1 ☑ Natural 1 ☐ Yes 2 ☐ No death. 2 Accident the 1 hours after death uneral Director: 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier P18173 FEB 02, 2008 PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUZH GREEN STREET BACTIMALE, MD alad SAEDI 33 32. Registrar's Signature 31. Date filed (Month, Day, Year) 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03389 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) February 4, 2008 **Physician** Margaret Rhoten 1:30 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Parkville 2292 Lowell Ridge Road Apt. C If Under 1 Year If Under 24 Hrs. 8. Date of Birth Adaptho | Dave | Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 X F 85 216-14-0548 Maryland Director October 11. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. Count r 28a-f show notified at 1 ☐ Yes 2 ☑ No Parkville Director Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Department of Health and Mental Hygiene. Important: or items 23a or important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be not injury or other traumatic event, the Medical Examiner must be not injury or other traumatic event, the Medical Examiner must be not injury or other traumatic event. 21234 U.S.A. 2292 Lowell Ridge Road Apt C filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Gould Company Secretary 12 m's 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Josephine Neumeister Reed Charles ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elkridge, Maryland 21075 Ronald G. Bohn, Sr. - Son 8007 Cocan Way 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Feb. 6, 2008 | Towson, MD 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licensee 1 Welton Christin 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner Flor lation The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the use as t IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day been signed by the atte should be detached for 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Medical Certification: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has b rector, page 2 sl autonsy or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Hospital

29c. License number 41536 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raven BIVI, Re. 1+. MD 2/239

State Registrar

31. Date filed (Month, Day, Year) 0 FEB 2008

(Check only one)

29b. Signature and title of certifier

Registrar's Signature

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** February 4, 2008 8:32 PM Anne Michele Rossi /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days Months Hours Min 1 □ M 2 🗙 F Pennsylvania Director 169-34-0774 64 June 16.1943 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. 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Father's Name (First, Middle, Last) 2 should be finand Mental H Vogel Elaine Α. Weiss ဥ Simon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,33619$ 19a. Informant's Name/Relationship (Type. Print) item 27 ls 9414 Crescent Loop Circle, #204 Tampa, Florida Brother William J. Vogel 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages 'Department of H Important: If ite any injury or of 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 2-8-2008 Towson Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Moral /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a o h sequence of) Examine The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 ☐ Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 2410 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 | Yes 2 | → NO 1 1 Inpatient ٩ 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred Certification: 1 ANatural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of

State Registrar

DHMH 17 Rev 1/2001

N. Cheules

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CAADEN, MP

FEB 0 7 2008

31. Date filed (Month, Day, Year)

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32 Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February Physician 200^Y8^{a1} John F. Silber Jr. 12:38 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Aug | 6 , 1927 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Mary land 80 220-20-2152 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f shov a or 28a-f sh t be notified 1 ☐ Yes 2 No Director Maryland Baltimore Lutherville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 515 Brightfield Road 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No 1945 If Yes, Give Year or Dates: 1946 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married or. Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify: þ 3 ☐ Widowed 4 ☑ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than the M College (1-4or 5+) Elementary/Secondary (0-12) Consultant Management 7 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last, Be John F. Silber Sr. Ruth L. Franklin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Craig A. Silber, Son 208 Whitehall Court Voorhees. NJ 08043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc. 02/06/08 Baltimore, Maryland 21. Signature of Funeral Service Lishuse
Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PROGRESSIVE SUPPANUELEAR **Physician** STAPS /Medical Due to as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔼 o Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 [Inpatient Other: 4 Nursing Home 5 Residence 6 ther (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funeral Detely filled i hours a 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely f and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of D64395 FEBRUARY 5, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2+1 DANIEUR DOBERMAN, NO 6565 N CHARLES ST, 849E 209 BALTIMORE, MD 21204

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** 2, Joan A. Stoffel 2008 6:14 A February /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Franklin Square Hospital Rosedale Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🖾 F Director 74 04/09/1933 MD 218-28-2147 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a, State r 28a-f show notified at 1 ☐ Yes 21 No Directo MD Baltimore Nottingham 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural" or items 23a or 4217 Necker Ave. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) It of Health and Mental Hygiene.
If Item 27 is marked other than "natu or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 <u>Homemaker</u> Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Lyell Laura McGuire ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William H. Stoffel/Husband 4217 Necker Ave Nottingham MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 02/05/08 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Schimunek Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Failure hours /Medical Pulmonary Embolism Examiner 2 hours if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit rolonged Physician/Medical on a IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Peripheral Neuropathy, Subacute 2 No 1 Tyes 3 Probably 4 Unknown should h Completed Endocarditis 24b. Were autopsy findings available prior to completion of cause of death? Recurrent Urinary Tract 24a. Was an autopsy performed? Yes 2 No page Coronary 2 X No Artery Disease Infection 1∐ Yes 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 □ DOA P 28a. Date of Injury (Month, Day Year) 24 hours after death.

Funeral Director: After the etely filled in by the funeral 28b. Time of 27. Magner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 2 Accident 5 Pending investigation 1 □ Yes 2 □ No M 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature D2247 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter Holt, M.D. RMB#509 Baltimore, ND 21239

State Registrar

31. Date filed (Month, Day, Year)

Loch Raven 32 Registrar's Signature

BIYD

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Doris May Schmelyun January 30 1282 PM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST agnes
5. Social Security Number Hospital Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) . Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F 215-28-6328 73 Feb. Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2 X No Director MD Baltimore Arbutus 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code ms 23a or 1564 Sulphur Spring Road 21227 United States Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23sury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarence Hoffman Dorothy Reely 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 is any injury or other trauonce. Gloria Timanus - Daughter 121 Wilson Blvd SW, Glen Burnie, MD 21061 20b. Place of Disposition (Name of MD Veteran Cemetery (grantors) or other place)

AD Veteran Cemetery (grantors) 2-7-2008 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 □ Cremation 3 □ Removal from State Crownsville, MD 4 □ Ponation 5 □ Other (Specify) Crownsville 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Pulmonory Diseas Physician inknown disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) signed by the a d be detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perforn certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 🗌 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) January

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。 State Registrar

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All CETOPS
31. Date filed (Month, Day, Year)

900 Cotton Ave

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Spend

08-00983 Terrance Sneed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legib State of Maryland / Department of Health and Mental Hygiene

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ay Year 2008	Time of Death 2135 hrs
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	15-0036 filed within 72 hours after death with the Maryland I Hygiene ad other than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at once.		7901 Scott Rd				2078	5			USA				
	ith th		11. Marital Status	12. Was Dece	edent Ever in U.S	S. 13. Wa	as Decedent	of Hispar	nic Origin	? (Spec	ify Yes or No-	an Indian, Black,			
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ľ	21215-0036 hould be filed within 72 and Mental Hygiene. is marked other than tic event, the Medical	Be	Jeffery Smith 19a. Informant's Name/Relations	Lie (Time Drint)		10b Mailir	a Address	(Street a	andr	a Sn	ral Route Numb	er. City or To	wn, State,	Zip Code)	
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	imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Health and Mental Hygiene tant: If item 27 is marked other than 'or other transmatic event, the Medical or other transmatic event, the Medical		1 Burial 2 Crematio	n 3 Removal fro	Jili Otate	crematory or o		7 0-		0.0			1 1/		
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	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only one) 2 Medical E	caminer:On the basis	of examination	and/or investi	gation, in my	opinion,	death oc	curred a	t the time, date	and place, a	nd due to t	the cause(s)	
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	3		30. Name and address of pers Carol Allan, MD	on who completed car ssistant Medica		111 Pen	n Street, I	Baltimo	ore, MD	2120	1				
		tate			Registrar's Signa	ture	TE TO THE PERSON NAMED IN COLUMN 1				···················				
	Regis			7 2009	7	Re A	and t								

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** Month Year George 1937 Speights Jr. February 200 8 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Sinai Hospital of Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Months Days Hours Director 214-58-5050 05/26/1953 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h. County ral", or items 23a or 28a-f sh Examiner must be notified Yes 2 No Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 926 Belgian Avenue Apt. 2B 21218 U.S.A. death \ Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No 2 Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) upholstery Ucholsterer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Speights Sr. Mary Contee 19a. Informant's Name/Relationship (Type. Print) 19b. Mäiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 permit. Pages 1 and 2 Department of Health a Important: If item 27 is Mary Speights / Mother 926 Belgian Avenue, Apt. 2B, Baltimore, Maryland Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Zion Cemetery 02/12/2008 | Lansdowne, Maryland 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service Licensee 4611 Park Hgts. Ave., Baltimore, Maryland 21215 6. 23a. Part1. Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sepsis 44 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unions or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed physician ar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 donknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an s certificate has irector, page 2 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 hpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Funeral Dir 1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Sina

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

31. Date filed (Month, Day,

FEB

Year)

MD

3 Registrar's Signature

RES-000

2008

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 35 **Physician** Dianna J. Shriver OM topruari 5,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner tal timore Ftc GRENERAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June28, 1939 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex n vrs. last birthday 7. Age (**Funeral** Months Days Hours Min. 1 □ M 2 🛣 212-36-9009 68 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD Baltimore 1 ☐ Yes 27 No Director Middle River 10e. Street and Numbe 10f. Zip Code 10a. Citizen of What Country? Cool Breeze Drive 2 21220 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White Completed by 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 h and Mental Hygiene. 7 Is marked other than "n: Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl Gerecht ပ Anna Greensfelder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other trainonce. Richard Shriver /son 4004 Baker Lane Baltimore MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 ment of F 1 ☐ Buria! 2 ☐ Cremation 3 ☐ Removal from State 2/11/08 Bayview Crematory Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Juneral Service Lice Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, o shock, or heart failure. Lis has that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Immediate Cause (Final **Physician** MOUTH EPPUS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examine FUMOMOBY Sequentially list conditions, sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed attending physician and for use as the burial-transit ORONARY ARTER Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 ☐ Other (specify) signed by the aid be detached for 1 ☐ Yes 2 ☐ No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy performe this certificate Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Unpatient 1 | Yes 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manne eath 28a, Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 5 ☐ Pending investigation spital or Attendi iours after death. neral Director: A 1 ☐ Yes 2 □ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a
To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed, (Month, Day, Year) 29c. License number

Registrar

State

FEB 0

Lragat

31. Date filed (Month, Day, Year)

30., Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of W	arylariu	-	rtificate of		ind Menial n	Reg. No		00000
6.	Physic	ian	Decedent's Name (First, Middle 1. Decedent 1.						2. Date of D Month Feb.		y Year	3. Time of Death
d	/Medi	cal	4a. Facility Name (If not institution	Naomi Strol			4b. City, Town, o	r I continu			2008 Year	10:30а м
	Examir	ner		Cherrywood			Reiste		m		Baltim	ore
*	Funeral Director		5. Social Security Number 215–34–7495		je (In yrs. lasi 39	birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date of B	irth ay, Year	9. Births Coul	place (State or Foreign ntry) 'YLand
	and		Usual Residence of Decedent 10a, State 10b, County		10c. City, T	own or Lo	cation					10d. tnside City Limits
	Maryl -f sho	tor	Md. Carro	11	Fir	ıksbu	rg					1 ☐ Yes 2 No
	th the or 28a	lrec	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Cou	ntry?
	23a c	raiD	1811 F	awn Way			21048				U.S.A.	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show early injury or other traumatic event, the Madical Examinational perputitional and once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marri 3 1 □ Widowed 4 □ Divorced	If Yes Give)		Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Orig an, Mexican Specify:	jin? (Specify Yes or N , Puerto Rican, etc.)	0-	14. Race - Americ Black, White, Specify: Wh	
5-0	72 ho 'natur	eted	15. Deceden	t's Education st grade completed)	1	6a. Dece	dent's Usual Occup kind of work done DO NDT use retired	ation during most	of working	16b. F	Kind of Business/In	dustry
121	within ane. then	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NDT use retired Sewife	d)	,		I	
	Hygie Hygie other		17. Father's Name (First, Middle,	Last)		nou	semile	18. Mothe	r's Name (First, Midde		lomemaker	·
Maryland	Aental Aental rked c	To Be	Hans	Lampe					Clara E.	Ker	idig	
lary	2 shou and h is ma		19a. Informant's Name/Relations			_			r or Rural Route Num			Code)
	fealth m 27		Richard L. Str	oh, Jr.	DON DIO				ksburg, Mo			
Baltimore,	ment of h tant: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	pecify)		gree		rdens	Feb. 9, 200	8 Fi		
Bal	permit Depar Impor eny in		21. Signature of Funeral Service	Zelelara	lf		11605 Rei	sters	al Chapel,	Owin	gs Mills	21117 . Md.
1	Physician /Medical Examiner	er	23a. Parí1. Enteythe disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate	a	a consequen	<i>J</i> 5 ce of):	tage	Ben	cardiac or respiratory	arrest,	C	Approximate Intendal Between Onset and Death
68760,	death certificate be executed e attending physicien and of for use as the burial-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as								
O. Box	death cer e attendir ad for use	hysician/Me	IF FEMALE: 23b. Was decedent prepartition in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetat de	ath 3□	Ectopic pregnancy Other (specify)	,			23d. Date of delive Month	ery Day Year
rds, P.	es pe	by	Part II. Other significant condition	ins contributing to death b	nut not resulting	ng in the u	nderlying cause giv	en in Part I.		tobacco Yes 2		he cause of death?
Records,	ne law requir i has been si ge 2 should	Completed		/ Trem	in	-11				s an opsy formed?	24b. Were auto prior to co death?	ppsy findings wailable mpletion of cause of
Vital	in: Th	မ င်	25. Was case referred to medical	1 this	flys	rd (4		20 Pl	1 ☐ Yes	2 N		2 No
Ž	Physician: The lav this certificate has ral director, page 2	To B	examiner? 1 Yes 2 No	Hospital:	ent 2 ER	/Outpatien	t 3 DOA Oth	05	of Death (Check only sing Home 5 Res		6 □Other (Specif	<u>ــــــــــــــــــــــــــــــــــــ</u>
ion of	ding Ph h. After th funeral		27. Manne of Death 1 Natural 5 Pendin 2 Accident investig	gation	y Year) 28	b. Time of Injury	28c. Injun Worl		28d. Describe			<i>''</i>
Division	P # F C	Certification:	3 Suicide 6 Could determ	288. Place of Int	ury - At home c. <i>(Specify)</i>	, farm, str	eet, factory, office		28f. Location City or To	(Street al own, State	nd Number or Rura e)	l Route Number,
	To the Hospital or Atten within 24 hours effer deat To the Funeral Director: completely filled in by the	ledical	one) 2 Medical	g Physician: To the best Examiner: On the basis of and manner sta	f examination	dge, death and/or inv	occurred at the tin vestigation, in my o	pinion, deat	h occurred at the time	, date an	d place, and due to	the cause(s)
)	To To com	Z	29b. Signature and title of contifie	MD			29c. Licens	P7 50	Seene	29d. Da	ate signed (Month,	Day, Year)
0	7		/8/	who completed cause of c	leath (Item 23	a) (Type,	Print) 183	38 (Slene	Tu	e i	21208
	Sta Registr	_	31. Date filed (Month, Day, Year)	2. Registr	ar's Signature	1334	E)					

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2

2008

Black, White, etc.

Month

Day

Year

white

1157 AM

Birthplace (State or Foreign Country)

WV

10d. Inside City Limits 1 ☐ Yes 2 X No

15 State

JOSHUA

31. Date filed (Month, Day, Year)

MOSKOVITZ

2008

Registrar

South

32. Registrar's Signature

GREENE ST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #8, perFh, G876, 2/11/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Bernard Francis Smith Π2 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1536 Dellsway Road Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 8/18/19229. Birthplace (State or Foreign (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Months Min. Davs Hours 1 X M 2 □ F 85 Director 048-09-3646 CT Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore Towson 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1536 Dellswav Rd. 21286 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give WW II Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☒ No Specify ģ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Broker Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Frank J. Smith Elizabeth Lowe 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Acoraci/Daughter 4 Hidden Brook Ct., Phoenix, MD 21131 20b. Place of Disposition (Name of completely, crematory of other)
Hillton, Service
Corporation 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 02-06-2008 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd, Towson, MD 21204 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate enval Between ns**e**t and Death Immediate Cause (Final disease or condition resulting in death) Physician Dromary /Medical Due to (or as a con equence of): Examiner Sequentially list conditions, if any, learing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for sella consequence off Examine be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 22 No certificate has page 2 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 2 No 1 ☐ Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA this 5 Residence 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Janner of Death 28b. Time of 28d. Describe how injury occurred Certification: Director: After Hospital or Attending 24 hours after death. 5 ☐ Pending investigation atura 1 ☐ Yes 2 ☐ No 2 Cident npletely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral D ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the and manner/stated. 29c. License number 29b. Signature 29d. Date signed (Month, Day, Year) 36814 30 Name and address of person who completed cause of death (Ite (Type Print) SULT DR, SUITE 3-2 TOWSON MD ZIZON 2. Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [] For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 430 A M 02-05-2008 Claire G. Taylor /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Young at Heart Asst. Living Joppa 7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
Months Days Hours Min.
06-24-1936 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 1 ☐ M 2 🔀 F 212-34-7173 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 X No Directo Maryland Harford Fallston 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21047 U.S.A. 336 Old Joppa Rd Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: þ White 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Company Realator 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Adams Jenry J. Witthauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fallston, MD 21047 336 Old Joppa Rd (Daughter) Lauretta G. Ritter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Mem. Gardens | 02-08-2008 | Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air Inc. 610 W. MacPhail Rd Bel Air, MD 21014 Diane 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death NEO PLASM OF LUNGS Immediate Cause (Final disease or condition resulting in death) MXLIGNANT Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 1 No 1 ☐ Yes 2 ☐ No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Fother (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 1 Matural 5 Pending 1 Tes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DØØ 16389

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: Atter this certific completely filled in by the funeral director.

31. Date filed (Month, Day, Year) State Registrar

YER PECTO

VALARAO, M.D 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Funeral

Director

item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at

permit. Pages 1 and 2 should be filled wir Department of Health and Mental Hygienv Important: If Item 27 is marked other the eny injury or other traumatic event these

Physician /Medical

Examiner

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1716 HARFORD ROAD Suite 105 THUSTON ME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () [] [] For State Registra Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month 2=308 **Physician** rumi 2008 rances January /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Elizabeth Baltimore Center Narsing If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days 1 ☐ M 2 🕱 F 220-09-3286 98 Yrs 1909 Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State , or Items 23a or 28e-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heatih and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28e-1 show any injury or other traumatic event, the Medical Examinar must be notified at 1 Yes 2 XNo Director Maryland Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21229 USA 4410 Hooper Avenue Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Practical Nursing 12 Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Brinsfield Annie Newton 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Castle Dr., Berlin, MD 21811 Maurice Wheeler (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ty Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 2/5/08 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Survice Licunses 3620 Wilkens Ave., Baltimore, MD 21229 23a. Park Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Quset and Death Immediate Cause (Final disease or condition resulting in death) Crastrointes Physician day /Medical Examiner ementi ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit lure Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 3 Probably 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was and autopsy performant? Yes 2 No certificate has 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death | Check only one examiner Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 X Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medicai 29a. Certifier (X)Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

Avenue:

January

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Baltimore

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32. Registrar's Signature

Benson

30. Name and address of person who completed, as se o death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year) FEB 0 7 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 03404 State of Maryland / Department of Health and Mental Hygiene [] [] [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month EWIS 04 2008 5:30 a. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death n/a ManorCare Health-Roland Park Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1**X** M 2□F Yrs. 8-14-1925 MD 218-14-()686 Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 No 2 No Baltimore MD n/a 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3509 Springdale Avenue # 2 21216 USA 14. Race - American Indian, Black, White, etc. African-American Specify: 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married 1 ☐ Yes 2√☐ No Specify: 3√2 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Welder General Motors 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Morton G. Tolson Columbia E. Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3509 Springdale Avenue # 2, Baltimore, MD 21216 DeAnna L. Bryant/Step-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State t☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Veterans 2-11-08 Win's Mills, MD 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 21. Signature of Funeral Şervice Licensee Randoni (CC) 9200 Liberty Rd., Randallstown, MD 21133 Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARDIOMYOPA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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Items 23e

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel', or Iten any injury or other treumatic event, the Medical Examinations.

Baltimore, Maryland 21215-0036

Director

Funeral

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Physician/Medical Examiner The law requires that the death certificate be executed Be Completed by Certification: To death. in by

after death

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physicien: within 24 hours a To the Funerel L

Registrar

Medical

27. Manner of Death

2 Accident

3 Suicide

29a Certifier

4 - Homicide

29b. Signature and title of certifier

1 Natural

5 Pending investigation

6 ☐ Could not be

determined

29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DRIVE

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 02-05-2008

REISTERSTOWN MD 21136

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BUSINESS 327 Registrar's Signature 31. Date filed (Month, Day, Year)

FEB 0 7 2008

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any				b. County			own or Location							10d. Inside City Limits 1 X Yes 2 No
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygienie. Important: If it item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the McMcalcal Examiner must be notified at once.	. 7	21	Donation 5	eral Service Lice	nsee		22. N	lame and Addre	ss of Facility	Wyli	e Funeral	Home :	P.A. 0	of Balto. Co.
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Division of Vital Records, rat or Attending Physician: The law require rape death.		린	3 Suicide	6 Could n	ot be	n nijary - Acci	iomo, rami, ou	000, 10000, 7, 1			or Town, S			
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and to the Funeral Director: After this certificate has been signed by the attending physician and	completely filled in by the Tuneral director,	<u> </u>	(Check only one) 2	Medical Examir	ician: To the best on ner:On the basis of each manner state	examination a	and/or investig	ation, in my opir	nion, death o	occurred a	at the time, date	and place, an	id due to	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Margaret Jayne Taylor February 2008 12:40 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Baltimore Towson I If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Min. Hours 1 M 2 X 212-26-2421 82 1-2-1926 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits N/A YXYes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3132 Abell Avenue 21218 TISA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 200 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XXNo Specify: Specify: white 3 Vidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Secretary Medicine/Health Care 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) J. Deane Taylor Margaret Gibson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Adams (Nephew) 508 Old Pasture Lane Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ₩₩ Burial 2 Cremation 3 Removal from State Parkwood Cemetery 2/7/2008 4 ☐ Donation 5 ☐ Other (Specify) Parkville, Maryland of Funeral Service Licenses 22. Name and Address of Facility 21. Signatu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death)

a. Net State Neuroencarre (ARCANO resulting in death) Burgee-Henss-Seitz Funeral Home, 3631 Falls Road Baltimore, Maryland 21211 Approximate Interval Between Opaet and Death Se_uentiall, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation

Physician /Medical Examiner

Physician

/Medical

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural" or framment.

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Examine Physician/Medical

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Completed

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Certification: To

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

and the attending physician been certificate this After t

Hospital or Attending Physician: The law requires that the death certificate be executed after death

Division or Vital Records, P.O. Box 68760,

To the Hospital within 24 hours at To the Funeral E completely

> State Registrar

6 ☐ Could not be

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TREDEU W IGLEHALT, III, M.D. 63C

6301 N charles St, Baltamore, MD 21212

and manner stated.

31. Date filed (Month, Day, Year) 0

32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

03407 State of Maryland / Department of Health and Mental Hygiene $\angle \cup \cup \exists$ 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** P^{M} February 3, 2008 6:50 /Medical Dorothy V. Wilson 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Manor Care Nursing Home Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1□M 2MF Yrs. Director 80 212-26-3174 Maryland 5/10/27 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits ill item 27 is marked other than "naturel", or lisms 23a or 28a-f show or other treumatic event, the Madical Examinar must be notified at 1 XYes 2 No Director Baltimore MD n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21239 1373 E. Northern Parkway by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after of Hygiene.

Other than "naturel", or Itel 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Depertment of Health and Mental Importent; If Item 27 Is marked o Edward T. Jackson Mary Ransom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21239 1373 E. Northern Parkway Daughter Angela Wilson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Injury o 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 2/8/08 Arbutus, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part1. Enter the disease, or comp shock, or heart failure. List only ations that caused the death. Do not enter the n Approximate Interval Between ode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dee to (or as Examiner ed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No.
9 ☐ Unknown Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably Whiknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 26 No 24b. Were autopsy findings available prior to completion of cause of death? certificate has 20 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 2 No 1 Tes 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this To the Hospital or Attending Pl within 24 hours after death.
To the Funeral Director; After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) t 🔁 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) e of death (Item 23a) (Type, Print) 30. Name and address of person who completed c OSLON Dr. AKHAD 7000 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ADBERT P

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician 2008 9:23 /Medical Mary E. Wickman February 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 83 215-22-6525 October8,1924 Maryland Director Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Baltimore Baltimore MD 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1011 Cord Street 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt: If Item 27 is marked other than "natural", or ite 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If Item Z7 is marked other th any injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Otto G. Wickman Esther Redemann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1011 Cord Streeet Baltimore, MD 21220 Edward E. Wickman/Brother 20b. Place of Disposition (Name of cematery, crematory or other place)
Moreland Memorial 20a. Method of Disposition 20c. Location - City or Town, State 1 ∏Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 □Removal from State Baltimore, MD Mace Avenue Baltimore 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Connelly Funeral 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Breast **Physician** years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Hother (Specify) Wispul 1 ☐ Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Funeral Director: stely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 29a. Certifier ≠ certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ٥ and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles ST TONSON NO 21204 32. gistrar's Signature 31. Date filed (Month, Day, Year, State Registrar 2008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February **Physician** 5, 2008 2008 Donald Edwin Wasti 3:20 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Milford Manor Nursing Home Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/11/1942 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F 149-34-5826 65 Director New Jersey Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Upperco 1 ☐ Yes 27 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17010 Pleasant Meadow Road Funeral 21155 United States 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American : Black, White, etc. 1 ☐ Yes ② No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo β Specify: White 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rudolph Wasti Helen May Lillich ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kristin W. Marquis (Daughter) 1264 Laurel Oak Lane, York, PA 17403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 2/6/2008 Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21 Signature of Funeral Service Licenses 4107 Wilkens Avenue, Baltimore, MD 21229 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Whenon Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions outing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performe death? 1 ☐ Yes 2 ☐ No 1∐ Yes 2 1No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To

Physician /Medical Examiner

ages 1 and 2 should be filed within 72 hours after death with the Maryland nt of Heath and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or or or other traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be ment of Health and Ments ant: If item 27 is marked

permit. Page Department o Important: If i

Baltimore, Maryland 21215-0036

"natural", or items 23a or adical Examiner must be r

Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760.

and burial-tra physician the for use the detached ģ g funeral director, page 2 should certificate I After 1 hin 24 hours after death the Funeral Director: filled in by

this

or Attending

1 ☐ Yes 2 No 27. Manner of Death

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

completed c

28b. Time of 28c. Injury at Work? Injury

1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only one)

30. Name and address of

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

1 / Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of

29d. Date signed (Month, Day, Year)

State Registrar

completely

2

31. Date filed (Month, Day, Year) 2008



death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician 6:20 AM 02/05/2008 Katherine L. Weckesser /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Convalescent Center Crofton <u>Anne Arundel</u> 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 04/18/1930 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F 218-26-0767 MD Director 77 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location s 23a or 28a-f show 10d. Inside City Limits MD 1 ☐ Yes 2 No Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 Lincoln Ave SW 21061 Ū.S.A. death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give or Items is 1 and 2 should be filed within 72 hours after des of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items other traumatic event, Ite Medical Examinal in 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☒ No Specify: ð 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruth Hartung 2 James Talley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun once. Mr. Arthur Childress 102 Lincoln Ave; Glen Burnie, MD 21061 son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation Glen Haven Mem. Park 02/09/2008 Glen Burnie, MD Other (Specify) yral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature M01411 Services; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** hei resulting in death) /Medical Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and A requires that the death certificate be executed burial-t Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medicai as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknowh jo Month Year Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? The law 24a. Was an page 2 has autopsy 1 Yes or Attending Physician: rector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: ၉ 1 🔲 Inpatient 2 ☐ ER/Outpatient ā Nursing Home 5 Residence 6 Other (Specify) 3 DOA this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: Division 1-Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide To the Hospital 24 hours a 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Midical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title directifier SCI 0201 21510 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ø Rakesh Arora 14300 Gallant Fox Lane Suite 222 Bowie, MD 20715 32. Registrar's Signature State 0 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. ZUU Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** \mathbf{F} . 02-05-2008 7:19a^M RUTH WILSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY CO. HOLY CROSS HOSPITAL SILVER SPRING 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Months 1 □ M 2 X F 79 VIRĞINIA 05-01-1928 Director 231-28-7038 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Director MONTGOMERY SILVER SPRING MD 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 20904 11446 LOCKWOOD DRIVE, #204 U.S.A. Funeral 72 hours after death Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CERTIFIED NURSING ASST. PRIVATE and 2 should be filed w lealth and Mental Hygie m 27 is marked other tl 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FLOOD, SR. LULA PERKINS ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health at Important: If Item 27 is any Injury or other traus KENNETH R. WILSON - SON 11446 LOCKWOOD DR., #204 SILVER SPRING, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 □ Gremation 3-⊡Removal from State MD VETERANS CEM. Ø □ Other (Specify) 02-14-08 CHELTENHAM, MARYLAND 4 ☐ Donation. 21. Signatur 1 Fun a Service Licens 22. Name and Address of Facility RONALD TAYLOR II FUNERAL HM 108 W. NORTH AVENUE, BALTIMORE, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ABDOMINAL AORTA THROMBUS /Medical Due to (or as a consequence of): **Examiner** RHABDOMYOLYSIS Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed CONGESTIVE HEART FAILURE burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 → Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 20 No certificate 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA ို this funeral 27. Manner of Death 1 Z Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0056063 FEBRUARY 5, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KANWALJIT NAGI 1500 FOREST GLEN RD., SILVER SPRING, MD 20910

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

State

Registrar

within 24 0

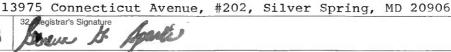
> 31. Date filed (Month, Day, Year) JAN 24 2008

John McNeil, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one)

29b. Signature and title of certifies



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D46584

29d. Date signed (Month. Dav. Year)

January 23, 2008

			1 _ State	artment of Health and Mental rtificate of Death	2000	3 031.13
			Registrar 1. Decedent's Name (First, Middle, Last)		Reg. No. 4 UU	2 Time of Dooth
No.	Physici /Medic		Lela Albright	Janu	h Day Year	3. Time of Death 04:45 PM
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dea	ath
			1617 Cape May Road	Essex	Baltimon	re
п	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday.	If Under 1 Year If Under 24 Hrs. 8. Date Months Days Hours Min. (Mon		rthplace (State or Foreign country)
la .	Director		297-32-7077 13 /3	Aug	22 1934 Mai	cyland
	and w		Usual Residence of Decedent	ocation		10d. Inside City Limits
	sho sho	5				TX□Yes 2□No
	the N 28a-f lotifi	Director	MD Baltimore Essex 10e. Street and Number	10f. Zip Code	10- 0:4:()45	
	aor	급			10g. Citizen of What C	
	eath	eral	1617 Cape May Road 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21211	United Sta	
	Iten Iner	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ∑ No	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et	c.) Black, Wh	
39	irs af	b	If Yes, Give 3X Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:	Specify:	nite
ŏ	filed within 72 hours after death with the Maryland Hygiene. I Hyan "natural", or Items 23a or 28a-f show ther than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	P P	15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b. Kind of Business	
215	hin 7.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of working DO NOT use retired)		
21.	d with giene er tha the	ĕ		oment Operator	Bausch & 1	Lomb
פ	e file al Hy othe vent,	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, N	liddle, Maiden Surname)	
Jai	s 1 and 2 should be filed within 72 hours after death with the Marylan if Healm and Mental Hygiene if them 21th and Mental Hygiene "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	P P	Henry Golden Mayle	Beulah Alice	Moore	
ary	s ma		19a. Informant's Name/Relationship (Type. Print) 19b. Mail	ng Address (Street and Number or Rural Route	Number, City or Town, State,	Zip Code)
Σ	1 and 2 Health a em 27 Is		Mrs. Alice Smith, Daughter 1617	Cape May Road, Essex	MD 21211	
ore	of He		20a. Method of Disposition 20b. Place of Disposeries of Disposeri	osition (Name of Date matory or other place)	20c. Location - City o	r Town, State
Baltimore, Maryland 21215-0036	Pages nent of ant: If its ary or o		1 [X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) George (!	Swanton, N	4D
a E	permit. Pag Department Important: I any Injury o once.			2. Name and Address of Facility David A. Burdock Fund		
m	8 3 E E E		Katherine Sweiter	21 N. Second St., Oal	land, MD 215	50
8			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician	r i	Immediate Cause (Final disease or condition	Chnes		Onset and Death
	/Medical		resulting in death) Due to (or w a consequence of):			- 1 400
E	Examiner		Construction that are distinged by			
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ursease or injury			
	ecuter nd transi	Examiner	triat initiated events C.			
Ö,	e exe		resulting in death) Last Due to (or as a consequence of):			
8760	ate be executed hysician and the burial-transit	dical	d		-	-
9		Mec	IF FEMALE:			
Вох	death certifica e attending pl ed for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	Ectopic pregnancy	23d. Date of de Month	elivery Day Year
O	0 0 0	/sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown 5	Other (specify)		Day Year
<u>.</u>	requires that the een signed by th hould be detache	F	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Port (23e	Did tobacco use contribute	to the equippe of death?
Vital Records,	ires t signe	b	Taken Start Significant Continues to Continue and Continues to Continue to Con	indenying cause given in ranti.		Probably 4 Unknown
0	w requir been si should I	Completed			1 1es 2 10 5 1 F	TODADIY 4 LIOTKIOWII
ခ်	The law te has b	nple		24a.	autopsy prior to	autopsy findings available completion of cause of
<u></u>	cate pag	Co		1	performed? death? Yes 2 ☑ No 1 ☐ Ye	
Z Z	sician; The law certificate has l irector, page 2 s	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death Check		
ō	this ald	P	1 Inpatient 2 ER/Outpatie		Residence 6 □Other (Sp.	ecify)
	ling After une	ioi	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury	Work?	cribe how injury occurred	
<u>S</u>	or Attending ufter death. Director: After in by the fune	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, st		tion (Street and Number or F	Trend Clareta Miracka
Division	I or Attend after death Director:	Certification:	4 Homicide determined building, etc. (Specify)		or Town, State)	nurai noute ivarriber,
	spita ours neral filled	Ö	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	h occurred at the time, date and place, and due	on the cause(s) and manner a	as stated
	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred at the	time, date and place, and du	ue to the cause(s)
	Nithin Somp	Me	29b. Signature and title of certific	29c. License number	29d. Date signed (Mor	nth, Day, Year)
			Mr. C. Morrel	0 34 931	1 28 10	8
•		1	30. Name and address of person who completed cause of death (Item 23a) (Type	Print)		
		1/	Dr. Ann C. March 4136	BE Jopald, Buti	me : M	7 (123)
	Sta	te	31. Date filed (Month, Day, Year) 32. Redistrar's Signature			
	Registr	ar	JAN 3 1 2008 Marine It 1	toorte		

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Funeral Director		5. Social Security N		6. Sex		Age (In yrs. I		If Under Months	Year Days	If Under 2	24Hrs. 8. D		`	Fore	irthplace (Sign Mar	State or ylan d
		218-68-48 Usual Residence of	Decedent	1M	2[X]F		48 Yrs.				l Ma	у 9,	1959 Country) 2			
w any			10b. County			7	, Town or Location	on								ide City Limits Yes 2 X No
yland n-f sho	ţċ	MD 10e. Street and Nur	Garre	= 119		Acc	cident	10f. Zip C	nda.			10	a Citizen	of What Co		Z K 110
the Ma n or 28	Director	28856 Gar		Hiahwa	ıv				520				USA		,	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "matural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	uneral	11. Marital Status 1 Never Marrie		12.	~			Decedent	of Hispa		n? (Specify ` Puerto Rican			Race - Ame White, etc.	rican India	an, Black,
after de	by Fu	3 Widowed	4 Div	orced If Yes	tes'	2 X No	1	Yes 2	No	specify:			Spe	ecify: Wh	ite	
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3876 rtificate ing phy as the b		IF FEMALE: 23b. Was decedent past 12 months	pregnant in th	23	c. If yes, ou Live birt	tcome of preg	gnancy	tal death	3	Ectopic p	pregnancy			Date of delive onth	ery Day	Year
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Division of Vital Records, tal or Attending Physician: The law requir and are death. al Director: After this certificate has been seled in by the funeral director, page 2 should it.	artifica	3 Suicide 4 Homicide	6 Cou		28e. Place ((Specify)	of Injury - At I	nome, farm, stree	et, factory, o	office bu	ilding, etc.		Location (S or Town, S		Number or	Rural Rout	te Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification:	29a. Certifier			o the best o		dge, death occur and/or investigat									(s)
To wit	Mec	29b. Signature and	title of certific		manner stat	teg.		29c.	License	number	OOUE		29d. Da	te signed (A	Month, Day	,Year)
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	10	30. Name and addr Theodore M					^{m 23a)} Examiner	111 Per	ın Stre	eet, Balt	timore, M	D 21201	l			
S Regis	tate trar		th, Day, Year)	2008	32. Regi	strar's Signal	ture Anna									

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

32. Registrar's Signatur

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** WILLARD ARTHUR BOARMAN JAN.30,2008 10:30A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11500 BB FARM PLACE CHARLES NEWBURG If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 577-38-6968 87 Director JUNE 12,1910 WASH., DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9350 WISE LANE 20646 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. within 72 hours after 1 □ Yes 2 □ NoMARINE
If Yes, Give
Year or Dates: WWTT 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No \$ Specify: WHITE 3 ₩idowed 4 Divorced WWTT Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FARMER 9th FARMING and Mental Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental JAMES WISE BOARMAN, SR. GRACE ALICE SMITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) if Health a litem 27 is other tra ROBERT A. BOARMAN-SON 11500 BB FARM PL. NEWBURG, MD. 20664 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If its any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST.MARY'S CEMETERY 2-5-08 NEWPORT, MARYLAND 2. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 21. Signature of Fweral Service Licensee M00479 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of be executed and Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 X Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To SONS HOME 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1. Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No re Hospital or Attendi 24 hours after death. 1e Funeral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Defical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. To the within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and

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State Registrar Charlene A Letch Ford, M.S. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

of MS 404 Charles St La Plata MO 20646
32 Registrar's Signature

D46419

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Month JOJCHE, /Medical DN1 4a. Facility Name (If not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death SE MALYLAND CELTER <AL JALTING V. G. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 K F Director 220-16-2305 82 Maryland Oct. 1925 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f sho 1 Yes 2 No Directo Maryland Frederick Keymar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 11927 Warner Rd. by Funeral 21757 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2X☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐**X**No 3X Widowed 4 ☐ Divorced Specify. White or than "natur the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roy Clemm Beatrice Hahn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S permit. Pages 1 and 2 s Department of Health ar Important; If Item 27 is any injury or other trau Wayne Bruchey/ son 11909 Warner Rd. Keymar, MD 21757 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chapel Cemetery 2/6/2008 <u>hr. Libertytown, MD</u> 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Licens 11802 Liberty Rd. Libertytown, MD 21762 23a. Part1. Enter the disease, or complications that could be death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ALLER SHATEL /Medical Due to (or as a consequence of): Examiner 4DELTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 😕 No 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 200 ٩ 1000 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar 31. Date filed (Month, Day, Year)
FFR - 7 2008

32. Registrar's Signature

GREENS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-00798 State of Maryland / Department of Health and Mental Hygiene Raymond Bender Certificate of Death 1- For State Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day January 29, 2008 0952 hrs Medical Examiner Raymond Bender 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince George's Hopsital Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Washington Months Days Hours March 15, 1955 country) Director 52 577-78-8126 1 X M 2 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No District of Columbia Washington items 23a or 28a-f show ust be notified at once. Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20019 4212 - 19th Place, 14. Race - American Indian, Black, Funeral 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Baltimore, MD 21215-0036
permit Pages I and 2 should be filed within 72 hours after death wit
Department of Health and Mental Hygiene.
Important: I filem 27 is marked other than "natural", or items 2
injury or other traumatic event, the Medical Examiner must be a If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 1 Yes **Black** 1 Yes 2 X No specify: Widowed Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Government Manager 12 years 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Barbara J. Smith Be Raymond Albert Bender, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4212 - 19th P1, NE Washington, DC 20019 Barbara J. Bender - Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Feb 11, 2008 Triangle, VA Quantico Nat'l Cemt. Donation 5 Other Specify 22. Name and Address of Facility Stewart Funeral Home, ignature of Funeral Service Licensee 4001 Benning Road, NE Washington, DC Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. Death /Medical Head injuries with complications Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and ian/Medical the attending physician ed for use as the burial -X UNPENDED #MENDED7, 28a-f, perME, g877, 3/5/08 TT Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Day Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) Physicia 1 Yes 2 No 9 Unknown g 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o No 3 Probably 4 V Unknown 1 Yes 2 ģ ۵ Completed 24b. Were autopsy findings available of Vital Records, 24a. Was an pnor to completion of cause of autopsy death? performed? has ✓ Yes No Yes 2 s certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other; Nursing Home 5 Residence 6 2 V ER/Outpatient 3 DOA Inpatient ilis: 1 V Yes 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death Yes 2X No Division Natura^t Pending subject assaulted Director: 9:15 pm /26/2008 2 Acciden Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Washington, DC 28e. Place of Injury - At home, farm, street, factory, office building, etc To the Hospital or At within 24 hours after d To the Funeral Direct or Town, State) Washington, DC 5000 Nannie Helen Burroughs Ave. N.E. Suicide Could not be determined (Specify) assisted living center 4 X Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. January 30, 2008 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. Assistant Medical Examiner 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 0 Margar 1 FFB Registra

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death **Physician** 2:35 P^M COURTLAND ROBERT BROWN JAN. 26 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CORSICA HILLS CENTREVILLE QUEEN ANNE'S If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
NOV. 15, 1921 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours **X** M 2 □ F 86 DELAWARE Director 220-03-9170 Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland Ih and Mental Hyglene.
7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 X No SUDLERSVILLE Director MD QUEEN ANNE'S 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21668 USA 120 WINTERACRE FARM LN Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) AGRICULTURE FARMER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be AGATHA DOWNES 2 WILLIAM BROWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any Injury or other traun once. JEAN WINTERSTEIN/DAUGHTER 118 WINTER FARM LN SUDLERSVILLE, MD 21668 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SUDLERSVILLE CEM. 1/30/2008 SUDLERSVILLE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee ELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-trar physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical the as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy signed by the atte in the past 12 months? 4□Pregnant at time of death 9□Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Unknown Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 2 🗌 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes >☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred or Attending 5 Pending investigation Natural after death.

Director: A
d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title 037936 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ÷ ol OP (), wonh 0 32. Regis r's Signature 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Ida Virginia Buckingham /Medical 26 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death Union Hospital Elkton, Cecil MD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 M 2 X 215-74-7641 Director 84 13. 1923 Millington Sept. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Cecil Warwick 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 228 Main Street 21912 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes → No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📆 💢 o Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th Homemaker Domestic/Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be fand Mental I Harvey Boyles Mollie Cazey and 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 of Health a ltem 27 is Harry L. Buckingham 228 Main Street, Warwick, MD 21912 permit. Pages 1 a
Department of He
Important: If Item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation — 5 ☐ Other (Specify) Townsend Cemetery 1/28/2008 Townsend, DE 21. Signature of Funeral Service Licensee DANIELS & HUTCHISON FUNERAL HOME LLC 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Inflammatory disease or condition resulting in death) /Medical to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and burial-tran Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical the as IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 1∐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: 1 Natural 5 Pending Injury To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar

133 N Bridge St., saltec, Elkton pap. 21921 HOSP/ce star's Signature Farkas casons 31. Date filed (Month, Day, Year) 32. Regis

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month. Dav. Year)

Andre Demetrius Bennett

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 03422 State of Maryland / Department of Health and Mental Hygiene

		- For State Certification - Ce	ificate of Death	Reg. No.
Physicia	an/	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year 1012 bro
dical Exami		ANDRE DEMETRIUS BENNETT		January 26, 2008
		4a. Facility Name (if not institution, give street and number) Frederick Memorial Hospital	4b. City, Town, or Location of Death Frederick	Frederick
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. las $218-84-8614$ 1×10^{-2} F 44	st birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min. Yrs.	Tourism TIACNITABUTORI TO
any		Usual Residence of Decedent	own or Location	10d. Inside City Limits
and f show	اة		REDERICK	1 X Yes 2 No
oith the Maryland 23a or 28a-f show	Dire	10e. Street and Number 542 WELLINGTON COURT	10f. Zip Code 21704	10g. Citizen of What Country? UNITED STATES
72 hours after death with the Maryland n"matural", or items 23a or 28a-f sho al Examiner must be notified at once,	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White, etc.
	<u>۾</u>	3 Widowed 4 X Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify: 16a. Decedent's Usual Occupation (Give kind of Victoria)	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Montal Hygield and anti-filed within and anti-filed 75 is marked other than "natural", or other traumatic event, the Medical Examiner	mpleted	Elementary/Secondary (0-12) College (1-4 or 5+) 12TH GRADE	during most of working life. DO NOT use reti	COSMETOLOGY
5-0(led wi Hygier other		17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)
21215 uld be fill Mental F marked c event, t	Be	JOHN BENNETT		LIZABETH EDELEN BENNETT Rural Route Number, City or Town, State, Zip Code)
e, MD 2. I and 2 should Health and M item 27 is mi	Δ	19a. Informant's Name/Relationship (Type, Print) GREGORY BENNETT, SR./ BROTHER	1706 OVERCUP OAK COUR	T, WALDORF, MARYLAND 20601
Baltimore, MC bernit Pages 1 and 2 s Department of Health at Important: If item 27		1 X Burial 2 Cremation 3 Removal from State	rematory or other place) MARY S CHIIRCH CEM FER	Date 20c. Location - City or Town, State NEWPORT, MARYLAND
Baltimo permit Page Department o Important: injury or oth	1	21 Signature of Europeal Signice Houses		
Ba Dep Depu		LIBIA C. THURNIUN JOHNSON MO0583	THORNTON FUNERAL H 3439 LIVINGSTON RO	IOME, P.A. AD, INDIAN HEAD, MARYLAND 2064
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/M. di l caminer			cic (heroin and methadone) :	intoxication Death
		Sequentially list conditions, b		
	ine	if any, leading to immediate cause. Enter Underlying Cause	e .	
cuted ind transit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)):	
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3760, ificate be g physical s the buri	N/M	IF FEMALE: 23b. Was decedent pregnant in the	nancy 2 Fetal death 3 Ectopic pregn	23d. Date of delivery nancy Month Day Year
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/Medical	past 12 months? 4 Pregnant at time of dea 1 Yes 2 No 9 Unknown 9 Unknown		
that the d	by Ph	Part II. Other significant conditions contributing to death but not re	sulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown
Division of Vital Records, P. tal or Attending Physician: The law requires the rs after death, all pirector: After this certificate has been signed in by the finneral director, page 2 should be defined in by the finneral director, page 2 should be defined.	Completed			24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
eco he law ate has age 2 s	티		<u> </u>	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
tal Rec cian: The certificate ector, page		25. Was case referred to medical	26.Place of Death (Check	k only one)
Vita nysicia nysicia nysicia direc	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓	ER/Outpatient 3 DOA Other Nursi	sing Home 5 Residence 6 Other:
n of ding Ph	on: T	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 1 Natural 5 Pending 1 1 1 (2000)	28b. Time of Injury 28c. Injury at Work? The 6.30 mm 1 Yes 2 X No	28d. Describe how injury occurred
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Divis pital or At ours after d eral Direc filled in by	Certification:	4 Homicide determined (Specify) found on	bathroom floor	Frederick Memorial hospital, David
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination at and manner stated.	ge, death occurred at the time, date and place, an nd/or investigation, in my opinion, death occurred	nd due to the cause(s) and manner as stated. If at the time, date and place, and due to the cause(s)
Z Z Z Z	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		Theodore M. He Thy Thy 30. Name and address of person who completed dauge of death (Item	O.C.M.E.	January 27, 2008
	1			vre MD 21201
BI		Theodore M. King, Jr., MD. Assistant Medical E		

			State Registrar			Certifica	ate of l	Death		F	Reg. N	0.			
¥	Physicia		1. Decedent's Name (First, Middle, Las	et Elizabe	th Baile	5 V				2. Date of Dea Month Januar	Da	5, 20	Year 008	3. Time 13:1	
	/Medic Examin	4	4a. Facility Name (If not institution, give			-	ty, Town, or	r Location (of Death			c. County			
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	Funeral		Social Security Number 6. S		(In yrs. last birth		der 1 Year			8. Date of Birt	h Voor		9. Birthp	lace (State	or Foreign
	Director		212-24-2526	□ M 2 X F	85 Yr	s. Month	s Days	Hours	Min.	May 12,					
	D		Usual Residence of Decedent												
	how at		10a. State 10b. County		10c. City, Town of	r Location							1	0d. Inside	-
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	or 28	Director	10e. Street and Number			10f.	Zip Code				10g. C	itizen of V	Vhat Cour	ntry?	
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	dea	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	13. Was De	cedent of H	lispanic Or	igin? (Spe	ecify Yes or No- Rican, etc.)	-		e - Americ k. White.	an Indian,	
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2-003p	72 hours after death with the Maryland natural", or thems 23a or 28a-f show sleal Examiner must be notified at	d by	3	Year or Dates:								, ,			
		Completed	15. Decedent's Ed (Specify only highest gra	lucation ide co <i>mpleted)</i>	16a. D	ecedent's U Give kind of ife. DO NO	sual Occup work done	ation <i>during mos</i>	st of worki	ng	16b.	Kind of Bu	siness/In	dustry	
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Mar	alth and 27 is m		19a. Informant's Name/Relationship (Florence Gwyndola			944 P				al Route Number					
อ์	s 1 a of Heal		20a. Method of Disposition		20b. Place of D	isposition (/	Vame of	ce)		Date	20c. l	Location -	City or To	own, State	
Ē	Page ent o nt: if ny or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Sacred H			1 1	Januar 200	ry 28,	Bush	wood,	Mary1	Land	
Dart	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service Licer				and Addre		ity	neral Ho	me,	P.A.			
			23a. Part1. Enter the disease, or com	plications that caused t	he death. Do no					own, MD		0		Approxim	ate
			shock, or heart failure. List only Immediate Cause (Final	one cause of each line	B.			_						Approxim Interval B Onset an	etween d Death
i Ana	Physician /Medical		disease or condition resulting in death)	a. Mob	Able	- MA	YUC.	M	911	LIw	17	reti	ion		
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	al-tra	xar	that initiated events resulting in death) Last	c Due to (or as a	consequence of):									
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ă	the death y the after iched for u	sician	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t		3 ☐Ectopi 5 ☐ Other	c pregnancy (specify)	у				Мо		Day	Year
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<u>s</u>	ttend death stor: the	cat	2 Accident investigatio 3 Suicide 6 Could not b	e 28e Place of injur	v - At home farr			103 2		28f. Location (Stroot	and Numh	er or Rur	al Route N	ımher
UIVISION	al or Attending F s after death. I Director: After id in by the funera	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	, 50000, 100	itory, onioc			City or Tol			er or man	ar Houte re	arriber,
_	pital ours erai filled		29a. Certifier 1 Certifying Pl	nysician: To the best of	f my knowledge	death occur	red at the ti	ime date a	and place	and due to the	cause	(s) and ma	anner as o	stated	
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical		miner: On the basis of and manner stat	examination and										e(s)
	o the	Me	29b. Signature and title of certifie	ſ			29c. Licens	se number			29d. E	Date signe	d (Month,	Day, Year)
	F S F O		1/h/h	1 dan	n		1) 2	428	>			1-1	· (/	08	
6	1		30. Name and address of person who	completed cause of do	ath (Item 23a) /T	vne Print\	Ul	125	3				, (0	
7) N		William D. Boyd, II,		Pt. Looko		Leo	nardto	wn. MT	20650					
	1		TELEVISION DO DO TURE ALL S	23303											

Registrar

JAN 2 8 2009

30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene)

. Simons	M01206	22955	Hollywood Ro	ad, Leonard		
he disease, or comp rt failure. List only Final	olications that caused the death.	Do not enter the mod	de of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death
n nai	a. Fatal	cardia	c dysrhyt	hmia		minutes -
- 4	Due to (or as a conseque					nours
nditions,	b. Due to for as a garaged line	•				minuter -
rlying injury	Section for the Contraction	100				Nous
ast	C Due to (or as a conseque	ance of):				
- L	240 10 (0. 40 4 0000400					
	d					
	23c. If yes, outcome pf pregnan					I
t pregnant months?	1 ☐ Live birth 2 ☐ Fetal o	death 3□Ectopic p			23d. Date of de Month	livery Day Year
No	4□Pregnant at time of dea 9□Unknown	ath 5 ☐ Other (s _i	pecify)			2.5,
icant conditions o	ontributing to death but not result	ing in the underlying	eause given in Part I	23e Did tohacc	n use contribute t	o the cause of death?
otitis /	Pancreatitis	ang ar are disacriying t	adde given in value.	1∏Yes		robably 4 Unknown
CICI 5 / I	rester caciffis			1 163	2 140 3 1	Tobably 410 OTKHOWN
emia	<u> </u>			24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
				performed 1 Yes 2 X	death?	· _
red to medical			26. Place of De	ath (Check only one)		
No	Hospital: 1 ☐ Inpatient 2 E	R/Outpatient 3 D	OA Other: 4 Nursing I	Home 5 ☐ Residence	6 □Other (Spe	ecify)
h 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how in	jury occurred	
investigation		M	1 ☐ Yes 2 ☐ No			
6 ☐ Could not be determined	28e. Place of injury - At hom building, etc. (Specify)	ne, farm, street, factor	y, office	28f. Location (Street City or Town, St.	and Number or R	ural Route Number,
	, starting, star (spearity)			City of Yown, St	116)	
Certifying Ph	ysician: To the best of my know	ledge, death occurred	at the time, date and plac	e, and due to the cause	(s) and manner a	s stated.
∠ Medical Exam	niner: On the basis of examination and manner stated.	on and/or investigation	n, in my opinion, death occ	urred at the time, date	and place, and du	e to the cause(s)
Tile of certifier		29	c. License number	29d. I	Date signed (Mon	th, Day, Year)
K//	MD		00064519	J	anuary	27, 2008
ess of person who	completed cause of death (Item 2	23a) (Type, Print)				
McGove			conard tou	in MD	20650	
th, Day, Year)	32. gistrar's Signatu	re		1		
JAN 30	2008 Been A	1 Speech	,			

03424

3. Time of Death

10d. Inside City Limits 1 ☐ Yes 2 No

Maryland

Black

4:32 p

State Registra

Hospital or Attending Physician:

s after death.

I Director: /

within 24 hours at To the Funeral D

Be

ဥ

Certification:

DHMH 17 Rev 1/2001

Jill

25. Was case referred to medical examiner?

1 ☐ Yes 2 No

27. Manner of Death

Natural 2 Accident

3 ☐ Suicide

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ORIGINAL

20		1 - For State Registrar	State of Maryla		tificate of			Reg. No.	UUB	03423
Physici /Medio		1. Decedent's Name (First, Middle, Last Timothy Lowell	Bowen				2. Date of De Month Januar	Day 28,	Year 2008	3. Time of Death 4:27 p
Examir Funeral	ier	4a. Facility Name (If not institution, give St. Mary's Hospita 5. Social Security Number 6. Se	7. Age (In yrs	. last birthday) Yrs.	Leonard If Under 1 Year Months Days	If Under 24 Hrs	8. Date of Bin (Month, Da	St.	Coun	lace (State or Foreign
Director	_	218-52-6352 Usual Residence of Decedent 10a. State 10b. County	58 10c. C	ity, Town or Lo	cation		02/16/1	.949	Mary	0d. Inside City Limits
with the Ma a or 28a-f	Dire	Maryland St. Mary		ington	10f. Zip Code				n of What Coun	•
be filed within 72 hours after death with the Maryland hall Hygiene. Ad other then "natural", or items 23a or 28a-f ehow event, it a Medical Examinar must be notified at	Completed by Funeral	46546 Midway Drive 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Ovorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1	20653 Was Decedent of I I Yes, specify Cub	Hispanic Origin? (san, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	- 14.	ed Stat Race - Americ Black, White, Decify: Whi	an Indian, etc.
d within 72 ho giene. er then "netur , tte Medicel	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12		(Give	lent's Usual Occup kind of work done DO NOT use retire ruck Dri	during most of wo	rking		of Business/Ind	dustry
d 2 should be filed within and Mental Hygiene. 7 is marked other then treumatic event, Italia	To Be C	17. Father's Name (First, Middle, Last) Briscoe Burdel Bow	en				me (First, Middle, Mae Buck		mame)	
and 2 sho salth and I n 27 le mu er treumu		19a. Informant's Name/Relationship (Ty Christy Long/Daugh	ter	P.O.	Box 134.	and Number or R		and the same of the same		Code)
permit. Pages 1 and 2 should by Deparmit. Pages 1 and Menta Important: if Item 27 is marked any injury or other treumatic evonce.		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State	Place of Dispo cemetery, cren	sition (Name of natory or other pla		Date	20c. Locat	tion - City or To	
permit. Depart Import any inj		21. Signature of Funeral Service Licens Kyle S. Simons	M01206	22	. Name and Addre .955 Ho11	ess of Facility Br ywood Ro	insfield ad, Leon	Fune ardto	ral Hom	ne, P.A. 20650
Physician /Medical Examiner	er		Due to (or as a conse	(AC quence of):	1	7 Tol/4V		rrest,		Approximate Interval Between Onset and Death
ficate be executed physician and is the burial-transit	dical Exar ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.							
death certi e attending ed for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	Ectopic pregnanc Other (specify)	у		23d	I. Date of delive Month	Dry Day Year
The law requires that the desate has been signed by the a page 2 should be detached for	by	Part II. Other significant conditions con	ntributing to death but not re	sulting in the ur	nderlying cause giv	ven in Part I.		obacco use (es 2 🗆 N		ne cause of death? ably 4 Unknown
: The law recate has be page 2 sho	Completed						24a. Was autop perto 1 🗆 Yes		24b. Were autoprior to condeath?	psy findings available inpletion of cause of 2 No
Attending Physician: Ther death. ector: After this certificate by the funeral director, pag	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	ospital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inju	ner: 4 🗆 Nursing l	ath (Check only of Home 5 Residence 1 28d. Describe I	dence 6		/)
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stre	eet, factory, office		281. Location (S City or Tov		lumber or Rura	l Route Number,
ne Hospitt n 24 hours he Funera	edical C	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my kn ner: On the basis of examin and manner stated.	owled_e. death ation and/or inv	occurred at the til restigation, in my c	me, date and place opinion, death occ	e and due to the urred at the time,	cause(s) an date and pla	d manner as st ace, and due to	ated the cause(s)
withi	Me	29b. Signature and fittle of certifier	- <u>^</u>	10	29c. Licens		-		igned (Month,	
UAV	te	30. Name in add as of person who co	mpleted cause of death (Ite 25500 32. Registrar's Sign	POINT	Looka Looka	OT ROAD	1 (501)	MANO	WN M	B) 2008 D 20658

BOWEN, TIMOTHY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month BIRCH HEODORE 1220 AM JANUARY 2008 30 /Medical 4a. Facility Name_(If not institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death CITY HOPKINS TOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) February 25,1954 Social Security Number 9. Birthplace (State or Foreign **Funeral** Months 1**X** M 2□ F 53 212-66-3746 Maryland **Director** Usual Residence of Decedent 10c. City, Town or Location 10a, State show 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland St. Mary's Piney Point 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 20674 17526 River Drive Funeral USA death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite any injury or othe traumatic event, the Medical Examine. 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify à Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond Thompson Birch Ada Stone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes Elizabeth Birch / Wife 17526 River Drive, Piney Point, Maryland 20674 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Holy Face Cemetery 2, 2008 Great Mills, Maryland 21. Signature of Funeral Service Licents 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. uchael prdiner P.O. Box 270, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) N'TRACERE BRAL HEMORRHAGE **Physician** DAYS /Medical Due to (or as a consequence of): Examiner MALGNANT if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, signed by the attending physician the detached for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signated bage 2 should b 2 No 1 ☐ Yes 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 2 Accident Injury e Hospital or Attendl 24 hours after death. e Funeral Director; A 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral Completely filled ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JANUARY 30, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

RECINOS.

2 2008

Year)

FEB

DHMH 17 Rev 1/2001

SHUS HOPKINS HOSPITAL 600 NOTH WATE STREET

THE

gistrar's Signature

M.D.

32.

State of Maryland / Department of Health and Mental Hygiene [] [] [1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Pearl Burkhead Bobbitt 4:30 A M January 26, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 11529 Pinesburg Road Williamsport Washington If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Months Days Hours Min 216-14-8277 Director 14, Unknown Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28e-f show treumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2√ No Director Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21795 11529 Pinesburg Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian a filed within 72 hours after da Hygiene.
Angiene.
other than "natural", or item Black, White, etc. 1 Never Married 2 Married 1 Tes 2 No
If Yes, Give
Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 6 Teacher Education Pages 1 and 2 should be filed vent of Health and Mental Hygie out: if Item 27 is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lingurn Burkhead Bobbitt Pearl Hissey Bowen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Williamsport, MD 21795 Kathy Shank - Friend (Per. Rep) 11529 Pinesburg Rd. other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State permit. Page Department o importent: if any injury or once. ö 5 Other (Specify) Rose Hill Cemetery 01-30-2008 Hagerstown, Maryland 4 □ Donation 22. Name and Address of Facility Osborne Funeral Home, P.A. 21. Signature of Funeral Service Conococheague St. Williamsport, MD 21795 23a. Part1. Enter the disease, or com shock, or heart failure. List only Approximate Interval Between Onset and Death complications that caused the only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Pnysician USHE disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ō Dav Yea 4 Pregnant at time of death 5 Other (specify) P.O. the δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No 2 No 1 Yes 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) Certification: 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending death. investigation 1 Yes 2 No after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide filled in 24 hours a the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29b. Signatu 29d. Date signed (Month, Day, Year) 29c. License number 2 Aance ttyscc10 on who completed cause of death (Item 23a) (Type, Print) 15H-6 13424 Pennsylvania Ave. Stephen E. Metzner, M.D. Hagerstown, MD 21742 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 2 8 2008

			For State Registrar		Sta	te of I	Marylan	id / Depa	artmen rtificat	t of H e of L	ealth a Death	and M	ental Hy	giene Reg. No		031	+28
			Decedent's Name	e (First, Middle	, Last)		-						2. Date of De			3. Time	of Death
н	Physici	an	Almeda 1										Month	Da		ır	
	/Medi		4a, Facility Name (I				er)		4h City	Town or	Location of		Januar		. County of D	2:30	A. ^M
	Examir	ier	809 м.		•		,				ce Pa				Garret		
	Euparal		5. Social Security N		6. Sex	7.	Age (in yrs.	last birthday)		1 Year	If Under		8. Date of Bi	rth	9.1	Birthplace (State	or Foreign
	Funeral Director		217-80-8	8693	1 ☐ M 2		82	Yrs.	Months	Days	Hours	Min.	Month, D	ay, Year)		Country) aryland	or r oroigir
			Usual Residence of				02		L1			1	100. 3	172.	1 111	aryrana	
	ylen how		10a. State	10b. County			10c. Cit	y, Town or Lo	cation							10d. Inside	City Limits
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	n the	<u>ē</u>	10e. Street and Nur	nber					10f. Zip	Code				10g. Cit	izen of What	Country?	
	738 o	0	809 м.	Street					2.1	550				Unit	ted St	ates	
	deet	Funeral Director	11. Marital Status		12. Wa	s Decede	ent Ever in U	.S. 13. \	Was Dece	dent of Hi	spanic Ori	gin? (Spe	city Yes or N		14. Race - A	merican Indian,	
9	or its	Ē	1 Never Marri	ed 2∭ Marri	ed 1	ned Force						, Puerto F	lican, etc.)		Black, W	hite, etc.	
8	Par,	5	3 ☐ Widowed	4 Divorced	Yes	es, Give ar or Date	s:		1 🗆 Yes	2LXI No	Specity:				Specify:	White	
21215-0036	within 72 hours effer deeth with the Maryland ane. than "natural", or iteme 23a or 28e-f ehow ia Medical Examinat must be notified at	Completed	(Snac	15. Decedent	s Education	(atad)		16a. Deced	ient's Usua kind of wo	of done	ition	of working	10	16b. K	ind of Busine	ss/Industry	
2	the state	de la	Elementary/Seco		Ť	llege (1-4	or 5+)	life. L	DO NOT US	se retired	uring mos	OF WORKIN	g				
	or the	5	7					Dish	Wash	er				Nu	rsing [Home	
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Maryland	Went Ment wrkec	2	Frank M	urphy							Ida	Mae	King				
ar	is 1 and 2 should of Health and Man Item 27 is marks other traumatic	1	19a. Informant's Na	me/Relationsh	ip <i>(Туре, Pri</i>	nt)		19b. Mailin	ng Address	(Street a	nd Numbe	r or Rural	Route Numb	er, City o	or Town, State	a, Zip Code)	
Σ	end 2 Belth n 27		Mr. Cla	ude Bec	kman,	Husb	and	809	M. S	treet	t, Mt	n. La	ake Pa	rk, 1	MD 215.	50	
re	of Heel Item 2		20a. Method of Disp					lace of Dispo	sition (Nan	ne of ther place	9)	Da	ate	20c. L	ocation · City	or Town, State	
Baltimore,	permit. Peges Depertment of I Important: if Ite eny injury or of		1 X Burial 2 (`4 ☐ Donation			I from Sta	110	er Park				eb. 2	2 2008	De	er Parl	k. MD	
Ħ	mit.		21. Signature of Fu				1,000	7	. Name an	d Addres	s of Facilit	v					
m	Depermine Depermine on y ir		NOM		Muriz				Dav:	id A	. Bur	dock	Funera	al Ho	ome, P MD 21	.A.	
			23a. Part1. Enter th	ne disease, or	complications	that cau	sed the deat	h. Do not ente	er the mod	e of dying	, such as	cardiac or	respiratory a	arrest,	MD 21.	Approxima	ate
	Dhysisian		shock, or hear Immediate Cause (rt failure. List (only one caus	se on eac	h line.									Onset and	
	Physician /Medical		disease or condition resulting in death)	n	а. <u>Д</u>	ther	OSC16	erotio	ca:	rdio	vasc	ula	r dis	ease	<u> </u>	- 7 mo	nths
	Examiner																
		er	Sequentially list con if any, leading to im	mediate	ь. <u>D</u>	labe Due to (or	tes r	nellit	cus,	typ	e II					yrs	
	pe tisc	무	cause. Enter Under Cause (Disease or that initiated events	rlying injury													
	xecu end	Examine	resulting in death) L	ast	C	Due to (or	as a conseq	uence of):									-
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68760,	ficate be execute physicien end is the burlel-trens	dical			d												
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Вох	atter for L	lar	23b. Was decedent in the past 12	months?	10	Live birth	2 ☐ Feta t at time of d	Ideath 3□	Ectopic pr Other (sp						23d. Date of Month	Day	Year
0	0 0	Physician/M	1 ☐ Yes 2 ☐ 9 ☐ Unknown	3 €40		Unknow		eau: 5_	1 Other (sp	о сн у)							
α.	£ 28		Part II. Other signific	icant conditio	ns contributir	a to deat	h but not res	ulting in the ur	nderlying c	ause give	n in Part I.		23e. Did	tobacco u	use contribute	to the cause of	death?
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€C	e law has l	du											24a. Was	psy	prior	autopsy findings o completion of	
F	n: The i licate ha r, pege	Ö											1 Yes	ormed?	death 1 🗆 Y		
¥	Physician: this certific ral director,	Be	25. Was case referr examiner?	red to medical	Hospital							of Death	(Check only	one)			
to	Physi this al dir	ို	1 ☐ Yes 2 🔀		Hospital	1 🗆 inp		ER/Outpatien			4 ∐ Nu				6 □Other (S	pecify)	
Ē		Certification;	 Manner of Death StNatural 	n 5 ☐ Pending		Date of I (Month,	njury Day Ye <i>ar)</i>	28b. Time of Injury		8c. Injury Work	?		8d. Describe	how inju	ry occurred		
Division	or Attending ifter death. Director: Aftei in by the fune	cat	2 Accident	investig 6 ☐ Could n					M	1 🗆 Y	es 2 🗆 !	No					
≥	i or Atten efter deat Director: I in by the	E	3 ☐ Suicide 4 ☐ Homicide	determi		Place of building,	Injury - At ho etc. (Specify	ome, farm, stre	eet, factory	, office		2	Bf. Location (City or To			Rural Route Nu	mber,
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	Hospital	cal	(Check only	1 Certifying 2 Medical E	p Physician: examiner: Or	To the be the basis	st of my kno s of examina	wledge, death tion and/or inv	occurred a	at the time	e, date and	d place, a	nd due to the	cause(s)	and manner	as stated. lue to the cause	(s)
	To the P within 2 To the F complete	Medical	Olive)		an	d manner	stated.	1									
L	5 1 kg 6 kg	=	29b. Signature and	titie of certifier	D.	1	1X			License						onth, Day, Year)	
•			+ Lova	191	NICA	41	Vat ?		D3	3003	5			01-	-29-20	908	
		5	30. Name and addre	ess of person v	vho complete	d cause o	of death (Item	23a) (Type,	Print)								
			Donald	R. Ri	chte				1emo:	cial	Dri	ve (Dakla	nd,	MD 2	1550	
	Sta		31. Date filed (Mont	th, Day, Year)	2008	32. Regi	istrar's Signa	ture	0					•			
	Registr	ar	,	ALIE 2	2000	F. C.	CAS	D. A	Deale.	5.							

			For State Registrar	State of	Maryland / Dep <i>Ce</i>	partment of Hertificate of I			ene 008	03429	
			Decedent's Name (First, Middle, La	st)				2. Date of Death	1	3. Time of Death	
	Physici		Edna Beitzel					January	Day Yea 26, 2008	A.4	
	/Medi Examir		4a. Facility Name (If not institution, giv	e street and numb	er)	4b. City, Town, or	r Location of Deat		4c. County of De		
М			Goodwill Mennoni	e Home		Grantsvi	lle		Garrett		
	Funeral		5. Social Security Number 6. S	ex 7.	Age (In yrs. last birthda	/) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth	Year) 9. 8	Birthplace (State or Foreign	
	Director		483-80-2580	□M 2 X F	98 Yrs.	Month's Days	Tiours With	March 28	3, 1909 P	country) ennsylvania	
	p ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Lagrica				10d. Inside City Limits	
	shov	J.								1 ☐ Yes 2X No	
	28a-f	Director	MD Garrett		Accident	T		10	o. Citizen of What		
	within 72 hours after death with the Maryland ans. then "natural", or iteme 23s or 28s-f show he Madical Exhibitor mast be militied at	ō	10e. Street and Number			10f. Zip Code	_			Country?	
	e 23	Funeral	9378 Rock Lodge I	12. Was Decede	ant Ever in II S 13	2152 . Was Decedent of H		Specify Vos or No.	USA	merican Indian,	
	item item	ů	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Force	es?	If Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)	Black, W		
99	irs at	by F	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give		1 ☐ Yes 2X No	Specify:		Specify:	White	
21215-0036	2 hou		15. Decedent's Ed			edent's Usual Occup		1	6b. Kind of Busine	ss/Industry	
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5	the die	E	8	College (114	Ho	omemaker			Own Home		
	e filed of ther vent,	0	17. Father's Name (First, Middle, Last,				18. Mother's Na	me (First, Middle, M	faiden Surname)		
<u>a</u>	Mentel 1	To B	Noah J. Maust				Annie	Yoder			
Maryland	\$ 5 E E		19a. Informant's Name/Relationship (Type, Print)	19b. Ma	iling Address (Street	and Number or R	ural Route Number,	City or Town, State	e, Zip Code)	
	1 and 2 Health a Iom 27 is		A. Leora Yaste/Da	aughter	9378	Rock Lod	ge Rd.,	Accident,	MD 215	20	
Baltimore,	of He		20a. Method of Disposition	***	20b. Place of Dis	position (Name of rematory or other place	ce)	Date 2	20c. Location - City	or Town, State	
Ĕ	Pages nent of h ant: if ite		1 🔀 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			Clade Ceme	tery Jan	. 29, 200	8 Accide	nt, MD	
att	permit. Pages Department of Important: If I eny Injury or anca.		21. Signature of Funeral Service Licer	1500		22. Name and Addre					
m	89 5 8		2 your	euna		P.O. Box	275, Gra	ntsville,	MD 215	36	
3	7		23a. Part1. Enter the disease, or co- shock, or heart failure. List only	plications that cau	sed the death. Do not e	inter the mode of dyin	ng, such as cardia	c or respiratory arre	est,	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition		^	red &	^	Lia		Onset and Death	
	/Medical		resulting in death)	a. Due to (or	as a consequence of):	week or	ariven.	1100		39447	
	Examiner		Comment the New year distance	b							
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or							
	cate be executed physicien and the burial-transit	Examin	if any, reading to intrinediate cause. Enter Underlying Cause (Disease or injury that initiated events	C							
o	e exe ien au urial-t	Ex	resulting in death) Last	Due to (or	as a consequence of):						
8760,	ate be nysici he bu	dicai		_ d							
99	ng pt	Med	IF FEMALE:								
Вох	The law requires that the death certific tie has been signed by the attending p age 2 should be detached for use as:	Physician/Me	23b. Was decedent pregnant	23c. If yes, outco		□Ectopic pregnancy	,		23d. Date of		
H	death ed fo	sicia	in the past 12 months?		nt at time of death 5	Other (specify)			Month	Day Year	
P.0	that the de led by the a detached t	'n.	9 ☐ Unknown								
Ś	igned be de	by	Part II. Other significant conditions of	ontributing to deal	th but not resulting in the	underlying cause giv	en in Part I.		\ /	e to the cause of death?	
Records,	w requir been si should	Completed	alrial	MDI	1 (action			1 ☐ Ye	s 2 No 3	Probably 4 Unknown	
ပ္ပ	has be	be		<i>U</i>				24a. Was ar autopsy	24b. Were	autopsy findings available to completion of cause of	
		PO.						perform	ned? death		
Vita	ysicien: Th is certiticate director, pag	Be (25. Was case referred to medical examiner?				26. Place of De	ath Check only one			
o t <	Q 50	2	1 Yes 2 No	Hospital: 1 ☐ Inp	patient 2 ER/Outpati	ent 3 DOA Oth	er: 4 Nursing I	Home 5 ☐ Reside	nce 6 Other (S	ipecity)	
			27. Manner of Death ↑ Natural 5 ☐ Pending	28a. Date of (Month,	Injury 28b. Time Day Year) Injury		y at	28d. Describe ho	w injury occurred		
Division	Mtendin death. ctor: Atl y the fur	Certification:	2 Accident investigation				Yes 2 □ No				
<u>≅</u>	or Attencatter death	Ĕ	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	Zee. Flace of	f Injury - At home, farm, : , etc. (Specify)	street, factory, office		28f. Location (Str. City or Town		Rural Route Number,	
	itel c irs af rei Di ted ir										
	d hou		(Check only 2 Medical Exar	ysician: To the be	est of my knowledge, de is of examination and/or	ath occurred at the tin	ne, date and place	e, and due to the ca	use(s) and manner	as stated.	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Attending the funething the fune formulately filled in by the fune	Medical	one)	and manne	r stated.						
	To To COT	2	29b. Signature and title of certifier	1_ ()	/	29c. Licens	e number		d. Date signed (M		
ł			Margaret	42	un M) DU	0650		1-28	-2108	
		1	30. Name and address of derson who	completed cause	of death (Item 23a) (Typ	e, Print)	1.0	01) /	1 2	
-		1	margaret a	Khiser	ud 1507	9 garret	Miglima	y oak	and, 1	-2008 W-21550	
	Sta	ate	31. Date filed (Month, Day, Year)	2008 32. Re g	jistrar's Signature	Society		/	/		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** M 550C 01 21 08 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Regional Medical Date of Birth (Month, Day, Year) (State or Foreign Age (In yrs **Funeral** Hours 1 □ M 2 🔭 F 214-42-8166 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Somerse Director Kc10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö Kiver 5815 or Items 23a Pages 1 and 2 should be filed within 72 hours after death v nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 1/2 If Yes, Give Year or Dates: 2 X No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No by 3 ₩idowed 4 Divorced 100 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) eac hore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly 20a. Method of Disposition ictoria 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of P Important: If ite 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State any Injury or Poromoko ~27-08 4 Denation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 122. Name and Address of Facility Bennie Smith forcal Home BOX331 Pocomoko City, and 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** oronan /Medical Chronic Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and burial-trar Due to (or as a consequence of) Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1☐ Yes Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 22 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29h Signature and title of certifier Jan 21, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nichael Basucl MD 100 E. CHILO Sa) (Type, Print) E, CMROLL St. SALISBURY Mcl. 2180/

State Registrar

31. Date filed (Month.

Day, Year)

2008

JAN 2 egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 23, Mavis Elizabeth Crump January 2008 12:00 p^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital
Social Security Number 6. Sex 7. Age (9. Birthplace (State or Foreign Country) Olney If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 🗗 F Months 578-38-2009 85 Director March 1, 1922 Washington, Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1X Yes 2 No Directo Maryland Montgomery Olney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18301 Georgia Avenue, #408 20832 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White ģ 3 Vidowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: if Item 27 is marked other any injury or other traumatic event; 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gordon E. Taylor Alice Elizabeth Sparshot 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Richard G. Crump/Son 4513 Morningwood Drive, Olney, MD 20832 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 24. Jan. 1 ☐ Buria! 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2008 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc
500 University Blvd, W., Silver Spr 21. Signature of Funeral Service Licensee 5 Silver Spring, MD 20901 23a. Part1. Inter the disease, or complications that cause if the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** /Medical Due to (or as a consequence of): **Examiner** ndo cardit Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner buriel-tran this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the buriel-trar Due to (or as a consequence of): Records, P.O. Box 68760 pe Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Programani 2 autopsy performed? 1∐ Yes 2 H No 2410 1 ☐ Yes Division or Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Hopatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 □ Yes 2 □ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 01/23/2008 D006 1681 10 80. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18101 Prince Philis Drue , o/ner Ki-Kealdy uD D. K.bert 31. Date filed (Month, Day, Year) egictrar's Signature State JAN 24 2008 Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 1:08PM January 28 2008 Gilbert Sylvester Crowe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Union Memorial Hospital 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Social Security Number **Funeral** Days Hours Months 1**K** M 2□ F 215-14-6163 April 28, 1920 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Ex miner must be notified at 1 ☐ Yes 2 No Director MD Garrett Lonaconing 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3251 Avilton-Lonaconing Rd. Funeral 21539 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: WW2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White þ Specify: 3 ₩ Widowed 4 Divorced 'natural", Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Heatth and Mental Hygien Imporant: If Item 27 is marked other th any injury or other traumatic event, the once. 10 Steelworker Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Edward Crowe Emma C. Wilhelm 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark A. Resh/Nephew 8354 Old Philadelphia Rd., Baltimore, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Grantsville Cemetery Feb. 2, 2008 Grantsville, MD 21. Signafure of Fungral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. 23a. Part1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Immediate Care (Final disease or condition resulting in death)

a. Preuma P.O. Box 275, Grantsville, MD 21536 Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-trar Due to (or as a consequence of): physician s the burial by Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe certificate 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient P 2 ER/Outpatient 3 DOA this : After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 🕅 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

P.O. Box 68760, Division or Vital Records, or Attending

after death, I Director: Af d in by the fur within 24 hours at To the Funeral Completely filled i

Medical

Registrar

4 ☐ Homicide

(Check only one)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier Alcheilih M.D. Elit

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AT 2438946

hospital

2008 28 January

Alcheikh MD union Elie memorial

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2008

			Registrar				Cert	titicate	Of L	Jeath			Reg. No.	000	0040
	sicia ledic	_	1. Decedent's Name (First, Mid-		othy Fa	ay Crawfor	d					2. Date of De		Year	3. Time of Death 2:20 P.M
	eaic min		4a. Facility Name (If not instituti					4b. City, To	wn, or	Location	of Death			unty of Death	
				ontgomery Ge				If I lead and	I	1011-1-1	Oln				tgomery
Fune Direc			5. Social Security Number 215-62-5334	6. Sex 1 □ M 2 💢 F	7. Age	(In yrs. last birt	rs.	If Under 1 Months [Year_ Days	If Under Hours	Min.	8. Date of Bir (Month, Da June	th ay, Year) 07, 1929	9. Birth Cou	place (State or Foreign ntry) Maryland
and w		-	Usual Residence of Decedent 10a. State 10b. Coun	v		10c. City, Town	or Loc	ation							10d. Inside City Limits
be filed within 72 hours after death with the Maryland ntal Hygiene. of other than "natural", or items 23a or 28a-f show count the Modical Evandor must ha notified at	ormed at	Funeral Director	Maryland	Allegany						Lonac	oning				1 X Yes 2 □ No
ith th	90	Dire	10e. Street and Number					10f. Zip C	ode				10g. Citizen	of What Cou	-
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Page Control			1 ■ Burial 2 □ Cremation 4 □ Donation 5 □ Other	(Specify)	n State		aure	l Hill Ce	met	ery		2008			lls, Maryland
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		4	30. Name and address of personal	on who completed ca	use of de	eath (Item 23a) (Type, F	Print)	,2,	helip	1-	Olne	1 20	732	
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State of Maryland / Department of Health and Mental Hygiene UUS Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2008 ar Georgette Patricia January 17, РМ Delaney 7:41 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5730 Moreland Drive South Frederick Adamstown | Honder 1 Year | Hours | 4 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | April 17, 9. Birthplace (State or Foreign Country) New Jersey 5 Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1941 1□M 2⊠F 137-32-4837 66 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23s or 28s-f ehow the Medical Examiner must be notified at Maryland Frederick Adamstown 1 ☐ Yes 2XXNo **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5730 Moreland Drive South 21710 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ⊠ No tl Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☒ No Specify: δ 3 Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Nurse 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 Health Care Registered Nurse/Practitioner es 1 and 2 should be filed vol Health and Mental Hygie of Health and Mental Hygie if item 27 is marked other to other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Howell Minnie Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Delaney / Son 924 Irving St., Philadelphia, PA 19107 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jan. 19. Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department of important: if eny injury or once. 2008 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Crematory Frederick, Maryland 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 21. Signature of Fun and Service Licens 9501 Catoctin Mtn. Hwy. Frederick, MD 23a. Part1. Enter the diseas shock, or beart failure or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final Ovarian Cancer Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physiclen end s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical 8 igned by the attending be detached for use as IF FEMALE 23c. tf yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ⊠Unknown pluods 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 hes autopsy performed? this certificete 1 Yes 2 No the funeral director, Be 25. Was case referred to medical 26. Place of Death Check only one examiner Hospital: 1 ☐ Inpatient Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) Certification; To 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Altert 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 ⊠Naturat 5 Pending within 24 hours efter death. To the Funsrs! Director: A 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 Suicide Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier completely (Check only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0061071 January 18, 2008 30. Name and address of person tho completed cause of death (ttem 23a) (Type, Print) Diana Juliano 610 Solarex Ct., Frederick, MD 21702 M.D.

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

JAN 2 5

Division of Vital Records, P.O. Box 68760,

32. Pegistrar's Signature

Division or Vital Records, P.O. Box 68760. within 24 hours a completely filled

Ø State Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier

ed (Month, Day,)

nd

rson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

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paddress of person who pempleted cause of death (Item 23a) (Type, Print)

32. Registrar's Sigoature

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Physicia		egistrar I. Decedent's Name (First, M	liddle,Last)				2	. Date of Death Month		Year	3. Time of Death	
l Examir			ELLE DAVID	SON				January 27	7, 2008		2130 hrs	
		a. Facility Name (if not instit	tution, give street and n	umber)	41	b. City, Town, or Lo	cation of Death		4c. Co	ounty of Deat	h	
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Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of birt	n(MM/DD	Forei	ign	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Year Mary Ruth Delozier January 29 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 1 □ M 2 🖺 F 63 219-46-9321 Director October 1, 1944 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at 1X Yes 2 No Maryland St. Mary's Director Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be r 28603 Point Lookout Road USA 20650 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖺 No White Specify: Completed by 3 ☐ Widowed 4 🖾 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School School 12 School Bus Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental Firem 27 is marked of Joseph Alton Bailey ၉ Rita Louise Vallandingham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa Dawn Delozier / Daughter P.O. Box 15 Morganza, MD 20660 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of P Important: If ite any Injury or ot February 4, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia 2008 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, PP.O. Box 270 Leonardtown, MD 20650 lardenon MChaels 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HYPOTENSION AND HYPOTHERMIA **Physician** disease or condition resulting in death) day /Medical Examiner mank METABOLIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner march attending physician and for use as the burial-transit RENAL FAILURE Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🔼 No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? recurrent 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Mapse with 74a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ⚠No autopsy performed? 1□ Yes 2₽No lure, anemia after death.

Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient 2 Impatient 3 Impo DOA 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0051738

35-

31. Date filed (Month, Day, Year)

32. Registrar's Signature

B 2 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KAE T. AUNG M.D. PO BO

DHMH 17 Rev 1/2001

State

Registrar

M.D. POBOX 37 HOLLYWOOD, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-00824 State of Maryland / Department of Health and Mental Hygiene Joseph P. Fotta 1- For State Certificate of Death Registrar 2. Date of Death . Decedent's Name (First, Middle,Last) Physician/ Month Day January 29, 2008 2354 hrs Joseph Patrick Fotta **Medical Examiner** c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Allegany Cumberland Cumberland Memorial Hospital 9. Birthplace (State or If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** oreign Days Hours Months 10/16/1962 NC Country' Director 242-11-3390 45 1X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 X No Washington Hagerstown MD items 23a or 28a-f show ust be notified at once. Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number US 21740 203 S. Fork Drive 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 1 X Yes White Specify: Yes 2 X No specify: 4 X Divorced If Yes Give Year Widowed ş 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) saltimore, MD 21215-0036
rmit. Pages 1 and 2 should be filed within 72 hou.
partment of Health and Mental Rygiene
portrant: If tiem 27 is marked other than "natu Completed Elementary/Secondary (0-12) Fire Protection Equip. Instal Fire Protection 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Lou Butler Francis Frederick Fotta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 203 S. Fork Drive, Hagerstown, MD 21740 Francis F. Fotta / Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 01/31/2008 Smithsburg, MD Smithsburg Crematory Department Donation 5 Other Specify 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Lights Potomac Street, Hagerstown, MD 21740 Approximate Interval Between Onset and 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Death Medica Methadone intoxication Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical e attending physician a for use as the burial - t X UNPENDED AMENDED #23a,27,28a-f, perME.g877, 3/5/08 TT The law requires that the death certificate be Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atter 1 Yes 2 No 9 Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o Yes 2 No 3 Probably 4 V Unknown þ Records, P. Completed 24b. Were autopsy findings available 24a. Was an been page 2 should prior to completion of cause of autopsy certificate has performed' death? Yes 2 V No 26. Place of Death (Check only one To the Hospital or Attending Physician: 25. Was case referred to medical director, Division of Vital Be Other₄ examiner? Hospital: Residence 6 Other: DOA Nursing Home 5 Inpatient 2 V ER/Outpatient 3 this 1 V Yes 28c. Injury at Work? funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 1 27. Manner of Death Certification: Yes 2 X No Natural n 24 hours after death.

ne Funeral Director: A steely filled in by the fu unk 5 Pending Fnd 1/29/2008 | Fnd 10:35 pm 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be 11818 Price Rd. Little Orleans, MD Suicide (Specify) found in house determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 30, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Patricia Aronica-Pollak MD. 31. Date filed (MoFFEB, V strar's Signature State 2008 A KACHARIE A Registra

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 15, 2008 **Physician** Fereidoon 1114 M Ghorashi January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospital Rockville Shady Grove If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 1**X**] M 2□ F 214-53-0312 Director 58 12/15/1949 Iran Usual Residence of Decedent 10a. State 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits Md. 1 ☐Yes 2X No Director Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r 10612 Wayridge Dr. 20886 Sweden/Iran Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Noble Construction and Mental Hygie Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jalil Ghorashi Heshmat Hashemi ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 is
any Injury or other trau wife Jila Kianni 10612 Wayridge Dr. Montgomery Village, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 DRemoval from State 4 Donation 5 Dother (Specify) National Memorial 1/20/08 Falls Church, VA 22. Name and Address of Facility Universal Mortuary 21. Signalup of Funeral Service 200 411 Kennedy St., N.W. Washington, DC20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Arrest 1 hour /Medical Due to (or as a consequence of): Examiner Myocardial Infarction hour Sequentially list conditions, any begins to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Unstable Plaque Rupture death certificate be executed burial-transi 1 hour Due to (or as a consequence of): Box 68760, physician Physician/Medical Artherosclerotic Cardiovascular Disorder years the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9□Unknown 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2X No 24a. Was an page 2 s certificate has autopsy 1∐ Yes 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 X ER/Outpatient 3 □ DOA ၉ After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death 2 Accident 24 hours after death e Funeral Director: the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical npletely (Check only To th. within 2. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 039372 NUINI Mh January 15, 2008 MAShin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20901 344 University Blvd. W. #324 Silver Spring, Rashid Baghai -Naini 31. Date filed (Month, Day, Year) JAN 24 egistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year Constancio Μ. Garcia January 2008 9:30 P. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Holy Cross Hospital 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 1**½** M 2 □ F Yrs 75 Sept. 1, 1932 218-11-7616 Philippines Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 12927 Matey Road 20906 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 21% No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 □ Never Married 2 N Married 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Asian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Mail Carrier U.S. Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Garcia Domingo Alejandra Macanas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosalinda Garcia/Wife 12927 Matey Road, Silver Spring, Maryland 20906 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 1/25/2008 Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licens 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a Cardiopulmonary Arrest Due to (or as a consequence of): Massive Stroke Sequentially list conditions Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🗌 No 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2X No 1 🔀 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

certificate be executed and I-tran physician at s the burial-t attending P.O. I signed by the Division or Vital Records. been this certificate After t or Attending hours after death.

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Examiner

Funeral

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Examiner

Physician/Medical

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29a. Certifier

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29b. Signature and title of certific

Examiner

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Medical

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Examiner must be notified

Director

Funeral

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funeral Certification: **Director:** þ within 24 hours a the Hospital Medical D

> State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) JAN 24



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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 65069

29d. Date signed (Month, Day, Year)

January 23, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 10:30 P^M 01/28/2008 RUTH AMELLIA HARRINGTON GSELL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CHESTERTOWN KENT CHESTERTOWN NURSING & REHAB Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 M 2 XF Yrs. MD 83 Director 218-20-6740 01/10/1925 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location a or 28a-f show 10a State 10b. County 1**X**Yes 2 □ No Director CHESTERTOWN MD KENT 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21620 items 23a permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must is 8603 ROCK HALL RD. by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE 3 ▼ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) SALES CLERK RETAIL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHN THOMAS HARRINGTON MADGE AMELLIA COLLISON ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) PATRICIA UNRUH/DAUGHTER 9749 AUGUSTINE HERMAN HWY. CHESTERTOWN, MD 21620 Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) CHESTER CEMETERY 1/31/2008 CHESTERTOWN,MD 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA 21. Signature of Funeral Service Licenses 130 SPEER RD. CHESTERTOWN, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one capital one each line. Immediate Cause (Final **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Be Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 X No 25. Was catecheferred to medical examiner? 2 No Yes 26. Place of Death (Check only one) 2000 Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 1 🗌 Yes Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Mariner of Death (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide

within 24 hours are: To the Funeral Director: Aft

State

Registrar

Medical

Rossm.D.

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29c. License number

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) Washing for Hoe.

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lesstation md 21620

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

32. Registar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 202008 /Medical 4c. County of Death 4b. City, Town, or Location of Death Aa. Facility Name (If not institution, give street and number) **Examiner** ester River Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Months Hours Min. 1□ M 2**X**F 81 9/27/1926 215-24-0769 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exminer must be notifiled at 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 No MD KENT ROCK HALL Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21244 CHESAPEAKE AVE 21661 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 🔀 No WHITE Maryland 21215-0036 Specify. Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LILLIAN LEAVERTON CLIFTON M. SMITH ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) PO BOX 105 ROCK HALL, MD 21661 SAMUEL E. GLENN/HUSBAND Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WESLEY CHAPEL 1/23/2008 ROCK HALL, MD 21. Signature of Funeral Service Licenspe FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA Kuk 0 130 SPEER RD. CHESTERTOWN, MD 21620 23a. Part1. Enter the disease, of completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a conselvi ence of): Physician /Medical Examiner Acmte 1 Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Ahheinen requires that the death certificate be executed physician and stranger the burial-tranger Due to (or as a consequence of): Box 68760, Physician/Medical as the attending potential to the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a Ö 9□Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed b d be deta Records, ģ 3 ☐ Probably 4 ☐ Unknown OSACO A MORAS page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2No 24a. Was an certificate has 1□ Yes Division or Vital 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ER/Outpatient 3 DOA 1 Tyes Certification: To this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Il or Attending Patter death. After (Month, Day Year) Injury 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 24 hours a Hospital 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title certifie MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Church Hill Rd Chestertown, MD MID Freckrick Delboy 6602 1775 32. Red rar's Signature State 2008 Registrar

			For State Registrar		State of M	arylan		artment of H rtificate of I		Mental Hy	giene Reg. No.	2000	}	03446
in	Physici	an	1. Decedent's Name (First,	Middle, La	st)					2. Date of De		Year		3. Time of Death 6:00
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je i	Examir	ner	4a. Facility Name (If not inst)			Location of Deatl	h		County of De		
			38734 Morr 5. Social Security Number	1S P		ge (In vrs. I	ast birthday)	Abell if Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	St. Ma		S e (State or Foreign
×.	Funeral Director	П	218-12-9098		I□M 2∰[F	90	Yrs.	Months Days	Hours Min.	June 25	$\frac{\text{ay, Year)}}{1917}$	7 Mai	country) rylar	nd
	and w		Usual Residence of Decede			10c. City	, Town or Lo	cation					10d.	Inside City Limits
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	tems termi	nue	11. Marital Status		12. Was Decedent Armed Forces	?	S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer	pecify Yes or No to Rican, etc.)	0-	 Race - Am Black, Wh 		
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	by	1 ☐ Never Married 2 ☐ 3 ※ Widowed 4 ☐ Div		1 ☐ Yes 2 ₩ If Yes, Give X Year or Dates:	No		1 ☐ Yes 2 💢 No	Specify:			Specify: W	hite	<u> </u>
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Maryland	should be f and Mental I s marked or umatic eve	To Be	John Foster							s Geneva		ŕ		
ary	shoul and M s mar	F	19a. Informant's Name/Rel				19b. Mailir	ng Address (Street	-				Zip Co	ode)
	Health a tem 27 Is		Delores Bur	ch /	Daughter		38734	Morris Poi	nt Road, A	bell, Mar	yland	20606		
Baltimore,	ges 1 t of He If Iten or oth		20a. Method of Disposition 1 X Burial 2 □ Crema	ation 3	Removal from State		lace of Dispo emetery, crer	sition (Name of natory or other plac	re) Feb	Date ruary	20c. Lo	cation - City o	r Town,	, State
ij.	t. Pag tment tant:		4 Donation 5 Dot	ner (<i>Speci</i>	(y) 1			ct Cemetery 2. Name and Addres	2.	2008	Bush	wood, M	aryla	and
Bal	permit. Pages 1 Department of H Important: If Ite any Injury or ot		21. Signature of Funeral Se	rvice Lice	Landing.	22)		O. Box 270					шп	idle, r.a.
	STREET, ST		23a. Part. Enter the disea	se, or com	cations that cause	d the death	-		•		-		Ar	pproximate terval Between
	Physician		shock, or heart failure Immediate Cause (Final disease or condition	. List only	one cause on each	ine. 4-05 (10001	11 CARA	10 VASCA)	se Dr	STASI		Or	nset and Death
	/Medical		resulting in death)		a. Due to (or as	a consequ	uence of):	11 CARD	1					mary.
к	Examiner	_	Sequentially list conditions,	- 1				MUMPIT	MIN	É			M	m/th.
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	₹	Due to (or as		TENS	ow					51	m7H.
Ć,	execuna and ial-tra	Examiner	that initiated events resulting in deeth) Last		Due to (or as	11-1							/	00/8
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	dical		•	d									
9 ×	ertifica ling pl	Med	IF FEMALE:		00-16			<u> </u>						
Вох	leath certific attending p	cian/	23b. Was decedent pregna in the past 12 months		23c. If yes, outcome 1□Live birth 4□Pregnant a	2 ☐ Fetal	death 3	Ectopic pregnancy Other (specify)			2	23d. Date of d Month	elivery Da	y Year
P.O.	that the de ned by the a detached i	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		9☐Unknown	at time of de	Saur JL							
ς, σ	res that igned b be deta	by Pi	Part II. Other significant co		-		/ -	nderlying cause give	en in Part I.	23e. Did	tobacco u	ise contribute	to the c	cause of death?
Records,	w require been sig should b		· 1/ 1/	IAL	1 BAILLA	1710W				1 🗆	Yes 2[□ No 3 □ I	Probabl	y 4 Unknown
ecc	law r las be	Completed								24a. Was	psy			findings available etion of cause of
		Con								perf 1□ Yes	ormed? 2 No	death? 1 ☐ Ye		□No
Vital	Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to m examiner?	edical	Hospital:			t 3 DOA Othe	26. Place of Dea	./			24	
ō	Phys	-: To	1 Yes 2 DW 27. Manner of Death		1 ☐ Inpati		ER/Outpatien 28b. Time of	I SU DOA	4 LI Nursing F	lome 5 Res			ecify)	
ion	Attending F r death. ector: After by the funers	ation	2 Accident	ending ovestigation		ay Year)	Injury		k? Yes 2∐No		,			
Division	r Attend er death. Irector: //	Certification:		ould not b etermined	Zoe. Flace of in	jury - At ho tc. <i>(Specify</i>	me, farm, str	eet, factory, office		28f. Location City or To	Street an	d Number or I	Rural R	oute Number,
	oital ours aft eral Di		17/									,		
	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 Ce (Check only 2 Me	rtifying Pl dical Exa	nysician: To the best miner: On the basis and manner s	of examinat	wiedge, deatl tion and/or in	n occurred at the tir vestigation, in my o	ne, date and place pinion, death occ	e, and due to the urred at the time	e ceuse(s) , date and	and manner and displace, and dis	as state ue to th	ed. e cause(s)
	To the within To the comple	Me	29b. Signature and title of	ertifier				29c. License	e number		29d. Dat	te signed (Moi	nth, Day	y, Year)
			· IX	M		N	70	1)(6096		1.	-30-	80	
0	2		30. Name and address of p					Print)	200 1	1.0 1.1 - 1.		WAS		120-
			10.011	Year	S. Gill	rar's Signat	MAH	288001	ates, H	unywe	ירטי	NI	>	10046-
?	Sta Registi	- 1	31. Date filed (Month, Day,		2008 32. Regist	iai a aigrial	M A	1/880 CI						
DHI	MH 17 Rev 1/2		FEB	L	2001	1000	30							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear 2008 Barbara Nadine January 18 6:40 Α Green 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5159 Woodville Road Frederick Mt. Airy 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 🖼 F 94 Jan. 1914 Maryland 219-36-0741 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Maryland Mt. Airy Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21771 United States 5159 Woodville Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: White Specify 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Philip Frank Scheel Barbara Ann Clay 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William F. Green, Sr. 26600 Haney Avenue Damascus, Maryland 20872 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition January 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 22, 2008 Mt. Airy, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Marvin Chapel Cem. 21. Si y ature of F 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 11-

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

sa or 28a-f show t be notified at

Director

Funeral

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Completed

Be

2

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

1 and 2 should be filed within 72 hours after death withealth and Mental Hygiene.
And Z is marked other than "natural", or items 23a arther traumatic event, the Medical Examiner must be the traumatic event, the Medical Examiner must be

t of Health a

item 27 other t

Department or Important: If i any Injury or once, = 5

/Medical

page

law requires that the death certificate be executed sician and burial-tran atter for u signed by the a cate After th funeral the Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division or Vital Records, P.O. Box 68760

	regulation in death)	a. Company of the contract of		17900
	resulting in death)	Due to (or as a consequence of):		
miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b		
dical Exal	that initiated events resulting in death) Last	Due to (or as a consequence of):		
ıysıcıan/me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
ed by Pr	Part II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to the cause of death? ☑ No 3 ☐ Probably 4 ☐ Unknown
Complet	Michite	melletus	24a. Was an autopsy performed? 1☐ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No
a)	25. Was case referred to medical		th (Check only one)	
0	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing F	lome 5 Residence	6 ☐Other (Specify)
IIIIcation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inju	ry occurred
,enilic	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, State	nd Number or Rural Route Number, e)
edicar	29a. Certifier (Check only one) 1	sician: To the best of my knowledge, death occurred at the time, date and place iner: On the basis of examination and/or investigation, in my opinion, death occurred manner stated.	e, and due to the cause(surred at the time, date an	s) and manner as stated. Id place, and due to the cause(s)
IVI	29b. Signature and title of certifier	29c. License number D3049	29d. Da	ate signed (Month, Day, Year)
	30. Name and address of person who co	Completed cause of death (Item 23a) (Type, Print) Parker, MD; 300 Wr 9th M;	Freberik,	1.11/2/70/

State Registrar

/anlis 31. Date filed (Month, Day, Year) cker, no. 32, Registrar's Signature 08-00879 Justin W. Gardner Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

	E	- For State Registrar	Certificate of	r Death		Reg.	No	
Physicia	n/	1. Decedent's Name (First, Middle,Last) Justin Wayne Gardner				2. Date of Death Month Danuary 31,	ay Year	3. Time of Death 1905 hrs
P → l Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death	January 51,	4c. County of Deat	h
		Washington County Hospital		Hagerstow	1		Washington	
Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Yea		_	MM/DD/YYYY) 9. Bi Forei	rthplace (State or gn Maryland
Director		217-79-3270 1Xm 2_F	Yrs	Months Day s. 5 4		August	27 07 C	ountry) at y tailu
		Usual Residence of Decedent	10c. City, Town or Loca	tion				10d. Inside City Limits
w an	- 1	Maryland Washington	•	 Hagersto	wn			1 Yes 2 X No
yland n-f sho	핡	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	untry?
or 28.	Director	13035 Resh Road		2	1740		U.	S.A.
with the 1s 23a se noti		11. Marital Status 12. Was Decedent			spanic Origin? (Sp		14. Race - Ame White, etc.	rican Indian, Black,
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f show any c event, the Medical Examiner must be notified at once.	Funeral		X No		n, Mexican, Puerto	Rican, etc.)	1.7h	nite
after	à	Widowed 4 Divorced If Yes, Give Year or Dates:	1_	Yes 2 X N		work done	Specify: W1.	
hours 'natu	Completed by	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12) College (1-4 or 5	during r	most of working life	etion (Give kind of e. DO NOT use ret			
36 hin 72 than '	ple	N/A	′	N/A			N	I/A
5-00 ed wit fygien other	히	17. Father's Name (First, Middle, Last)			18.Mother's Name	e (First, Middle, Ma	iden Surna m e)	
1214 lbe fill ental F arked vent, t	Be	Jason Lynn Gardner	Laguage	Address (0)	Pri	scilla Ni	cole Freder, City or Town, Sta	eze
MD 21215-0036 at 2 should be filed within 7 th and Mertal Hygiene. a 77 is marked other than umatic event, the Medica	2	19a. Informant's Name/Relationship (Type, Print) Angie Miller					Maryland	
2 2 2 2		20a. Method of Disposition	20b. Place of Dispo	osition (Name of c			20c. Location - City	
Baltimore, permit. Pages I an Department of He important: If ite	-1	1 XBurial 2 Cremation 3 Removal from Sta	crematory or d GreenLawn	otherplace) 1 Memoria	1 PK F	eb 5, 200)8 Willi	lamsport MD
Baltimo permit. Page Department of Important: injury or ott	-1	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	22.	Name and Addre	ss of Facility D	ouglas A.	Fiery Fu	neral Home
Depring Injury		Kaitlin Rattaroni			ern Blvd	. N. Hage	erstown Ma	aryland 21742
Physician		23a. Part I. Enter the dis so, or implications that caused failure. List only one cause on each line.	the death. Do not enter	the mode of dyin	g, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
Medical. xaminer	1	Immediate Cause (Final disease a. Pneumonia co		pulmonary	valve sten	osis		Death
		or condition resulting in death) Due to (or as a const	equence of):					
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a constitution)	equence of):					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a cons	equence of):					-
ecuted and - transit		d						
al al	n/Medical	X UNPENDED AMENDED 23a.	,27 per ME g87	78 4/8/08 a	emh			
68760, certificate be exending physician are as the burial	/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outco	· -	Fetal death	Ectopic pregr	nancy	23d. Date of deliv Month	very Day Year
x 68 h certi tendin use as	siciar	past 12 months?	time of dooth	Other (Specify)				
Box te death c the atten ted for us	Phys	1 Yes 2 No 9 Unknown g Unknown			a divers in Part I	23e Did tob	pacco use contribute	to the cause of death?
, P.O. Box 687 res that the death certifit signed by the attending be detached for use as the detached	by P	Part II. Other significant conditions contributing to deal	n but not resulting in the	e underlying caus	e giveiriii Fait i.			Probably 4 Unknown
ords, F w requires as been sig should be	ted					24a. Was a		autopsy findings available
COFC law re has be	Completed					autops	med? death	
tal Reco		25. Was case referred to medical		26.Pia	ace of Death (Chec	1 Yes 2	No 1 🗸	165 2 10
Vital Rec ysician: The l his certificate l director, page	o Be	everiner?	ent 2 V ER/Outpatie		Othor		Residence 6 O	ther:
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been seled in by the funeral director, page 2 should the funeral director.	n: To	27. Manner of Death 28a. Date of Inj	ury Year) 28b. Time (of Injury 28c. li	njury at Work?	28d. Describe h	ow injury occurred	
ion ttendi leath. tor: /	atio	Natural 5 Pending Accident Investigation		1_	Yes 2 No	1		Dural Davida Number City
Division pital or Attent ours after death eral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify)	njury - At home, farm, si	ireet, factory, offic	e building, etc.	or Town, St		Rural Route Number, City
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the		29a. Certifier	ny knowledge, death oc	curred at the time	date and place, a	nd due to the cause	e(s) and manner as	stated.
To the Howithin 24 h	Medical	(Check only one) 2 Medical Examiner: On the basis of examiner stated	amination and/or investi	gation, in my opin	ion, death occurred	d at the time, date a	and place, and due t	o the cause(s)
F X F S	Me	29b. Signature and title of certifier			ense number		29d. Date signed	
		Doma Milmonti, M.D.		0.	C.M.E.		February 1, 20	
مانم		30. Name and address of person who completed cause of Donna M. Vincenti, MD Assistant Med		11 Ponn Stro	et, Baltimore,	MD 21201		
DH-0	tata		ar's Signature	111 6111 0116				
Regis	tate trar	FFR (15 2008)	man B	park				
DHMH 17 Rev 1/2	2001	OCME	ORIGIN	NAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 13449 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^D27, 2008 **Physician** JANUARY 8:37 AM Vivian Simmons GREENE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Reeder's Nursing Home Boonsboro If Under 1 Year If Under 24 Hrs. Washington Birthplace (State or Foreign Country) 1 Year Days 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 ☐ M 2 💢 F Director 214-05-9842 90 Sept 1 1917 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f shov ner must be notified at 1 Yes 2 □ No Directo Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 141 S. Main Street Funeral 21713 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify ρ White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Sportswear Buyer Department Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Thomas Head Carrie Simmons 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Thompson - Niece 22013 Grove Road, Hagerstown, Maryland 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 1/28/08 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home James K. Spicer 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final is schuliz **Physician** Cendis Vana disease or condition resulting in death) Arter /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the detached 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Was a.. autopsy performed? Ves 2 100 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1□ Yes 1 Yes 2 🗆 No neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Addrsing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital or A 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

WH-3

State Registrar

VASANT DATTA, 340 MILL STREET, 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

aumo

JAN 2 8 2008

32. Registrar's Signature

P1081 a

JA~ 28, 2008

	4	FUL	partment of Health and Mertificate of Death		g. No.	03450
		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
Physicia /Medica		Robert Charles Helsel,	Sr	January		0315 A M
Examine	_	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		2890 Singerly Road	E1kton If Under 1 Year If Under 24 Hrs.		Cecil	La (Ghana a Faraire
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 212-26-2605 1 ☑ M 2 ☐ F 77 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, March 18,	Year) Cou	place (State or Foreign ntry) nsylvania
Director	-	212-26-2605 77 Yrs. Usual Residence of Decedent		reitir 10,		
yland		10a. State 10b. County 10c. City, Town or	Location			10d. fnside City Limits
e-fel	cto	Maryland Cecil Elkto	n			1 ☐ Yes 2 🌠 No
should be filed within 72 hours after death with the Maryland of Menial Hygiene. marked other than "natural", or items 23e or 28e-f show unatic event. The Medical Exempter count be coulded at	Funeral Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou United St	•
23a	rai	2890 Singerly Road 11 Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Amen	
permit. Pages 1 and 2 should be filled within 72 hours after de Department of Health and Mental Hygiene. mportant: if Item 27 is marked other than "natural; or item sny injury or other traumatic event. The Madical Exemi	Ę.		. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	, etc.
urs af	۵	3 Widowed 4 Divorced TATES 2 No Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Whi	ite
72 ho	Completed	15. Decedent's Education 16a. Dec	edent's Usual Occupation e kind of work done during most of work	ina	6b. Kind of Business/Ir	ř
vithin ne. hen	du	Elementary/Secondary (0-12) Coflege (1-4or 5+)	DO NOT use retired)		Automobile Manufactur	
Hygie Hygie ther t	ပ္ပ	12 1. Father's Name (First, Middle, Last)		e (First, Middle, M		IIIg
d be antal ced o c svs	To Be	Lincoln Edward Helsel	Hazel G	ood		
2 should be filed within and Mental Hygiene. is marked other than aumatic svant, the M	F		ling Address (Street and Number or Run	al Route Number,	City or Town, State, Zi	ip Code)
ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23e or 28e-f show or other traumatic event. The Madical Examinar must be malified at			Singerly Rd., Elk			
of He of He fiter r oth	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cherry		Date 2	Oc. Location - City or T	own, State
Pag ment ant: i		4 Donation 5 Dother (Specify) METROd1:	st Cemetery 2000		Cherry Hi	11, MD
permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any injury or other tra		21. Signature of Funeral Service Licensee	22. Name and Address of Facility icks Home for Fune 03 W. Stockton St.	rals, P.A	A. MD 01001	
ub = va		23a. Part 1. Enter the disease, or complications that caused the death. Do not eshock, or heart faifure. List only one cause on each line.	U3 W Stockton St. nter the mode of dving, such as cardiac	or respiratory arre	MD Z19Z1	Approximate Interval Between
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or Attending Physician: Ifter death. Director: After this certifics in by the funeral director.	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Str City or Town	reet and Number or Ru , State)	ral Route Number,
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical Ce	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or	with securified at the time, date and place investigation, in my opinion, death occu	and due to the ca	use(s) and manner as ite and place, and due	stated. to the cause(s)
To the within 2 To the complet	Med	one) and manner stated. 29b. Signature and Little of certifier	29c. License number	29	d. Date signed (Monti	n, Day, Year)
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183		30. Name and address of person was completed cause of death (Item 23a) (Typ	MO 3003545_		1 3 7 3 8	
D.,			. Suite 104 Elkt	on, MD 21	1921	
Cto	te	31. Date filed (Month, Day, Year) Registrar's Signature				

State of Maryland / Department of Health and Mental Hygiene UUU Certificate of Death 3. Time of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 230 Year PM **Physician** Hoffman 18 Michael Allen Jan 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Clear Spring Washington 12064 Big Pool Road 8. Date of Birth (Month, Day, Year) May 4, 1961 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X** M 2□ F 46 Yrs. Maryland 212-82-2276 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Heelith and Mentall Hygiene. Importent: If Item 27 is marked other than "natural", or Itame 23e or 28e-f ehow any injury or other treumatic event, Ita Medical Evandurance. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Director Maryland Washington Clear Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 12064 Big Pool 21722 Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Auto Body 12 <u>Auto Body Technician</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jean Audrey Miller Theodore Merle Hoffman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kelly Hoffman - Wife 12064 Big Pool Road Clear Spring, Maryland 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Mem. Park Feb.1,2008 Williamsport, Maryland 4 Donation 21. Signature of Funeral Service OSDOFFIE FUTTER FOR P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Renel Physician Cell Carcinone Yr. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed led by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Probably 4 Unknown LUNG 24a. Was an autopsy performed?
1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No this certificate has 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident efter death Director: 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours e To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1.29.08 041667 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Medical Cours Hagenston MO McCorneck 05H-2

State Registrar

Division of Vital Records, P.O. Box 68760.

31. Date filed (Month, Day, Year) JAN 2 9 2008



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21215-0036 d within 72 hours af giene. er then "natural", or	Cal E	ted		15. Decedent's Ed			a. Decede	nt's Usual Occup	ation	-6		16b. Kir	nd of Business	Industry	
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Maryland id 2 should be file th and Mental Hy 27 is marked other	aumatic event, the Medical Examiner must be notified at	Be (17. Father's Name (F								irst, Middle.		Sumame)		
arylan should be nd Mental	atlc	ပ္	WILLIAM (OODBUR				
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Balt permit. Departr	any injury or o) //A	Eday 1	Holand		ME	LSON FUN	ERAL S	SERVI	ÇES,LT	D AT	7ADE 10	0070	
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Dhusi	-1		Immediate Cause (F	inal	_									Interval Be Onset and	Death
Physic /Med			disease or condition resulting in death)		a. Due to (or as	a consequence	e of):	HK I KI	CÀ	DR	SIZA	-5 n			
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8760 cate be e	the burial-transit	dical			d										
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ecords, P.O. law requires that the as been signed by th	e deta	by P	Part II. Other signific	cant conditions co	ntributing to death b	ut not resulting	in the und	lerlying cause giv	en in Part I.		23e. Did to	obacco u	se contribute t	o the cause of	death?
Hecords, he law requires to has been signed.	should b										1 🗆 Y	es 27	_No 3 □ P	robably 4]Unknown
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VITAL ilcian: T	irector, page 2 s	e e	25. Was case referre	ed to medical					26. Place	of Death (C	Check only o	_			
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DIVISION of or Attending after death. Director: Afte	n by t	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inju- building, etc	ury - At home, c. (Specify)	farm, stree	et, factory, office		28f	Location (S City or Tox	Street and vn. State	d Number or R)	ural Route Nui	mber,
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To the within 2	completely	Mec	29b. Signature and t	itle of certifier	2112 11211101 010			29c. Licens	e number			29d. Dat	e signed (Mon	th, Day, Year)	
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William King

State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 7:00P M Mildred May Kitzmiller 2008 01 28 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mt. Lake Park Garrett 212 D Street If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🖾 F 87 Maryland Director 11/28/1920 215-36-7564 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f ahow the Medical Examinar than the notified at 1 ☐ Yes 2 ☑ No Director Mountain Lake Park Garrett Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21550 212 D Street Completed by Funeral 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) High School 12th Cook is marked other 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be flie.
Department of Health and Mental Hy
Important: if Itam 27 is marked other 17. Father's Name (First, Middle, Last) Be Elva Creighton Hill Eli Oliver Zimmerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 121 C Street, Mt. Lake Park, Maryland 21550 Louise Klier/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/01/08 Oakland, Maryland Pleasant Valley Cem. 21. Signature of Juneral Service/Licenses 22. Name and Address of Facility Stewart Funeral Home South Second St. Oakland, Maryland 21550 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 6 months KENAL **Physician** -81 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed anding physicien and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Medical Certification: To Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be deteched 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours efter death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, streel, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Fo the Hospital 29a. Certifier f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the lime, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D27205 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SCHWALM 31 KARL 32. Registrar's Signature 31. Date filed (Month, Day, Year) State **JAN 3 0** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10a-f per inf 26 per doc 2877 3-10-08 years and Mental Hygiene () () 03455 1- State Registrar Amend 10b, perFH, g877 3/6/08 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Yeer CHARLES KETTH LAWSON January /Medical 30, 2008 2:30 P 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 701 Ramsey Court - Apt. 102 Salisbury Wicomico 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) April 17, 1955 Birthplace (State or Foreign Country) 1**∑**M 2□F Months Days Hours Min. Director Yrs. 215-62-0154 Maryland Usual Residence of Decedent death with the Maryland 10a. State DE 10b. County 10c. City, Town or Location 28e-f show Sussex 10d. Inside City Limits Bethany Beach the must be notified at Some laryland Salisbury Director 1 Yes ZIXINO Wicanico 10e. Street and Number 115 Garfield Parkway 19930 10f. Zip Code 10g. Citizen of What Country? ö 701 Ramsey or items 23e 21804 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 reumetic event, If a Medical Exam þ 1 ☐ Yes 2X No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced neture!', Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner Grocery marked other 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hy tent: If item 27 is marked oth jury or other treumetic event 18. Mother's Name (First, Middle, Maiden Sumame) Be Alfred J. Lawson, Jr. Ruth Briddell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Dryden (Sister) 7201 Stevens Road - Eden, MD 21822 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or Sunnyridge Memorial Park `4 ☐Donation 5 ☐ Other (Specify) Crisfield, MD 21. Signature of Juneral Service 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, Robert H. Bradshaw, Jr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of): mo-th /Medical Examiner Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Teen Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician by Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) detached the 9 Unknown 9 🗆 Unknown ģ signed t Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No Completed 3 Probably 4 Unknown been s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed? Yes 20 No certificate 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Acidence 6X Other (Specify) Nother S ² 1 Yes 2 No 27. Manner of Death residence Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: the 2 Accident 6 Could not be determined 3 🗌 Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Dire 4 T Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 56093 MO Ch 10

DHMH 17 Rev 1/2001

State Registrar

Sairsbury,

Cote A solo

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Ruth Naomi Loepp 2:08 PM 02 01 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington Smithsburg 13227 Greensburg Road 8. Date of Birth (Month, Day, Year)
Nov. 25, 1919 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 ⋤ F 88 515-05-3780 Kansas Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Smithsburg Washington Maryland 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21783 U.S.A. 13227 Greensburg Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bank Cashier srmit. Pages 1 and 2 should be filled wi epartment of Health and Mental Hygien portant: If Item 27 is marked other thin y Injury or other traumatic event, the 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ona Pearl Eastlick William Isaac Swagerty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13227 Greensburg Rd. Smithsburg, Maryland 21783 (Daughter) Karen E. Loepp 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Februaru 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department o Important: If any Injury or 3, 2008 Smithsburg Crematory Smithsburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783 MO1414 avis 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nset and Death Immediate Cause (Final disease or condition 0 month **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed and Due to (or as a consequence of): Box 68760, physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performer 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by determined 4 Homicide Hospital or **Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) completely within 24 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00564/3 07/01/08

State

Registrar

CII

HABERSTOWN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

32. Registrar's Signature

WASeem

Khalid

7 2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Nancy C. Livingston 2008 1- For State Certificate of Death Reg. No. Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day January 27, 2008 1457 hrs Medical Examiner Nancy Carolynn Livingston c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Frederick Frederick 100 Key Parkway 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Min Davs Hours Country) Michigan Director 220-66-1886 2X F 49 Nov 8, 1958 1 M Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 No MD Frederick Frederick Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 100 Key Parkway 21702 Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces White, etc. Never Married 2 Married 2 X No Yes White Specify: 4 X Divorced If Yes, Give Year Yes 2 X No specify: Widowed ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) es 1 and 2 should be filed within 72 of Health and Mental Hygiene. Baltimore, MD 21215-0036 12 Beautician Beauty Shop Com 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is marked Gerald Thomas Christner Dorothy Eleanor Nelson (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2088<u>6</u> MD 19a. Informant's Name/Relationship (Type, Print) 8804 Walker's Choice Rd. If item 27 Dorothy E. Christner/mother #4 Montgomery Villa 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State 02/01/08 Chesapeake Crematory Beltsville, MD Other Specify Donation 5 Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, 21. Signature of Funeral Service License MD 21029 Approximate Interval 21a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician een Onset and failure. List only one cause on each line. /Medical Death a. Complications of chronic alcoholism Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical X UNPENDED ned by the attending physician detached for use as the burial -#E3a,27,perME,g876, 2/21/08 TT Division of Vital Records, P.O. Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 ✓ Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Yes 2 No 3 Probably 4 V Unknown δ Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? ✔ Yes 2 2 1 🗸 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: Residence 6 V Other: Scene Nursing Home 5 Inpatient ER/Outpatient 3 DOA 1 Yes No funeral 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death Certification 1 X Natural Yes 2 Director: Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 24 Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 28, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) EG. 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Patricia Aronica-Pollak MD. 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001 **OCME 2006**

State

Registrar

egistrar's Signature

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2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** James Robert Maguire February 2008 4:10 pm M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)
Oct 06, 1936 Frederick Vindobona Nursing Center 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 168-30-8123 71 Director Pennsylvania Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Pennsylvania Lancaster Lancaster Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2215 Marietta Avenue 17603 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married "natural", or White 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 No Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Shipping/Recieving Manager 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Meone. Elementary/Secondary (0-12) College (1-4or 5+) Wire Factory 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Howard Maguire Ellen Leckey 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Maguire, Daughter 5016 Canvas Back Ct, Frederick, Maryland 21703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory | Feb 4, 2008 | Smithsburg, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens e Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701 M00706 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failere. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition cell concer FEAR **Physician** disease or condition resulting in death) /Medical **Examiner** YEAR Sequentially list conditions, Due to for an a nonnecuanga cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Exam attending physician and for use as the burial-trai Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has lirector, page 2 s 1∐ Yes funeral director. Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Aursing Home 5 Residence 6 Other (Specify) 2□ No 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation after death.

I Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours at Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the

Division or Vital Records, P.O. Box 68760, or Attending Physician: Hospital

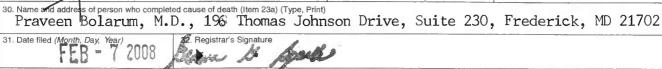
Baltimore, Maryland 21215-0036

State Registrar

29b. Signature

31. Date filed (Month, Day, Year) 2008

title of certifier



29c. License number

00062223

29d. Date signed (Month, Day, Year)

February 3, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UUU 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Katherine Alvina Mirfin January 2008 9:26 A^M 30 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4351 Middleburg Road Union Bridge Carroll 8. Date of Birth (Month, Day, Year June 6, 19 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours 1 □ M 2**X** F Maryland 1927 80 219-20-1799 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Carroll Union Bridge 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4351 Middleburg Road 21791 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) farm wife dairy/beef 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clara Blum George W. Owings 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Union Bridge, MD 21791 4351 Middleburg Rd. K. Dwayne Mirfin/ grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Deer Park Cemetery 2/2/2008 Smallwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Futheral Service Lice Turine 6 E. Broadway Union Bridge, MD 21791 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Physician /Medical Examiner

as the

ed by the a

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examiner

Physician

/Medical

Examiner

Funeral Director

Completed by

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10a. State

MD

Funeral

Director

Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 menths? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Tyes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number

within 24 hours a State

Registrar

the funeral

filled in by

after death.

2973 Menderson J. MD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Manchester

08-00911 Stu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

art Morrison			For State Control of Certificate Of Grant Control of Certificate O	Death		Reg. N	D	3. Time of Death
Physici		1.	Decedent's Name (First, Middle,Last)		2. Dat Mo Feb	te of Death nth Day Druary 1, 20	y Year	2025 hrs
dical Exam	Ime		a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Silver Spring			4c. County of Montgome	
	F	-	Holy Cross Hospital Social Security Number 6. Sex 7. Age (In yrs. last birthday)		24Hrs. 8. D	ate of Birth(M	M/DD/YYYY)	9. Birthplace (State or Foreign
Funeral Director			220-88-8441 1X M 2 F 46 Yr	Months Days Hours	Min. Ma	rch 23,		Country) Maryland
w any		_	Sual Residence of Decedent Da. State 10b. County 10c. City, Town or Local	tion				10d. Inside City Limits 1 Yes 2 X No
ne Maryland or 28a-f shnw fled at once	3	֓֞֜֞֜֞֜֞֜֞֜֞֜֞֜֞֓֓֓֓֓֓֞֜֞֜֞֓֓֓֡֡֡֡֡֡֡֡֞֜֞֜֡֡֡֡֡֡֡֡	Maryland Montgomery Silve 0e. Street and Number	Spring 10f. Zip Code		10g. (Citizen of Wha	t Country?
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death with the Maryland or items 23a or 28a-f shm			1 Never Married 2XXXMarried Armed Forces?	as Decedent of Hispanic Orig Yes, specify Cuban, Mexican,	in? (Specify Puerto Ricar	Yes or No- n, etc.)	14. Race - White,	American Indian, Black, etc.
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hours after death "natural", or iten Examiner must l			during	ent's Usual Occupation (Give k most of working life. DO NOT	kind of work of use retired)	ione 16	b, Kind of bus	iness/Industry
36 Thin 72 Pie.] :	blet	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Smal	1 Engine Mechanio			Sears	
21215-0036 and be filed within 72 Mental Hygiene. marked other than 'eyent, the Medical		Completed	7. Father's Name (First, Middle, Last)			t, Middle, Mai		
1215 Id be file Mental H		8	James Morrison	ng Address (Street and Num		ne Quich		n, State, Zip Code)
C of b is	<u> </u>	_	19a. Informant's Name/Relationship (Type, Print) Mary june Morrison/ Wife	1704 Brisbane St				
and 2 she lealth and reem 27 is	n ann		20a. Method of Disposition 20b. Place of Disp	osition (Name of cemetery,	Feb. Da		0c. Location -	City or Town, State
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Baltimore, MC permit. Pages 1 and 2 s Department of Health at Important. If item	ury or		21. Signature of Funeral Service Licensee	Name and Address of Facility rancis J. Collin	s Funera	al Home :	Inc.	
	_	_	23a. Part I. Enter the disease, or complications that caused the death. Do not enter	on University Bluer the mode of dying, such as o	cardiac or res	Silver	Spring, , shock, of he	MD 20901 Approximate Interv
Physicia Medica			failure. List only one cause on each line.					Death
amine			Immediate Cause (Final disease or condition resulting in death) a. Asphyxia Due to (or as a consequence of):		-			
			Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
		nine	cause. Enter Underlying Cause					
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Box 687 seath certification by	use as	cian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 4 Pregnant at time of death 5	Other (Specify)				
Boy e death the att	ed for	Physician/	1 Yes 2 No 9 Unknown g Unknown	no underlying cause given in F	Part I	23e. Did tob	acco use con	ribute to the cause of death?
ires that the signed by	detached	by P	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying dadde given in i				Probably 4 Unknow
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that that the direct cleath.	should be					24a. Was a autops		Were autopsy findings availa prior to completion of cause
COTC law re	e 2 sho	Completed				perform	ned?	death? 1 ✓ Yes 2 No
Re I: The tificate	ж, рав		25. Was case referred to medical	26.Place of Deat	h (Check onl	y one)		
Vita ysician his cer	direct	To Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpat	ient 3 DOA Other	Nursing l		Residence 6	Other:
of Vital Recing Physician: The After this certificate	uneral		27. Manner of Death 28a. Date of Injury (Month, Day, Yeer) 28b. Time	1 Ves 27	V No	subject a	sphyxiat	red while engaged
Sion vitend death. ctor:	y the f	catic	Natural 5 Pending Investigation 2/1/2008 Fnd 7 28e. Place of Injury - At home, farm.	:50 piii	etc. 2	8f. Location (S	treet and Num	activity ber or Rural Route Number,
Divis	ed in b	Certification:	3 Suicide 6 Could not be determined (Specify) Found regider		1	or Town, S 1704 Bris	sbane Sti	reet Wheaton, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	completely filled in by the funeral director, page 2		29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigations.	occurred at the time, date and	place, and di occurred at t	ue to the caus the time, date	e(s) and mann and place, and	ner as stated. If due to the cause(s)
To th withi	com	Medical	and manner stated. 29b. Signature and title of certifier	29c. License numb			29d. Date si	gned (Month, Day, Year)
		_	his his moo	O.C.M.E.			February	2, 2008
-			30. Name and address of person who completed cause of death (Item 23a)	tract Politimore MD 2	1201			
	-		Entiry Entire En	treet, Baltimore, MD 2	1601			
		tate trar	FFR U 4 / UK Magaza / Z	back				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) anuari Year 2:30 AM **Physician** WRRAG 2000 /Medical ∠ity/Town, or Location of Death 4c County of Death Facility Name, (If not institution, give street and number) Examiner Stertown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2**X** F 11/26/1920 MD 87 Director 215-16-3562 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 1 ☐ Yes 2 ☐ No Director BARCLAY QUEEN ANNE'S MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21607 1108 BARCLAY RD. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK Completed by 3 Notice 3 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) **FOOD** FACTORY WORKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be PEARL MCCOLLISTER ဂ္ EDWARD ROCHESTER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO BOX 117 BARCLAY, MD 21607 SANDRA E. JASON/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) BARCLAY, MD ST. DANIEL'S 1/26/2008 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA Kick A 130 SPEER RD. CHESTERTOWN, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ament disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 2 heimer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) physician a the burial P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown After this certificate has been signed by funeral director, page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Be Completed by 11cov 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mann of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a e Funeral I Hospital TE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only within 24 and manner stated. 29d. Date signed (Month/ Day, Year) 29c. License number 29b. Signature and title 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Main St. Galena, MD 119 MD 32. Register's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 95/M **Physician** INCEN 2008 /Medical Name (If not institution, give street and number, 4c. County of Dea Examiner GEN rulde If Under 24 Hrs. Date of Birth (Month, Day, Year) 6-8-1962 Birthplace (State or Foreign Country) Age (In yrs. last birthday) Year Social Security Number **Funeral** Days Months Hours **X** M 2□ F 45 Delaware Director 222-54-6898 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County ral", or Items 23a or 28a-f show Examiner must be notified at 1 HYes 2 □ No Director Delaware Kent Dover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 439 Arnold Ct 19901 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 2 If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black þ 3 ☐ Widowed 4 1 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) item 27 is marked other than "nature other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dickey's Restaurant Kitchen Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and M Georgia A. Winder Vernon D. Shockley Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8779 Hearing Branch Rd Lincoln, DE Vernon D. Shockley father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Department of Important: If it any Injury or o 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Siloam AME Church Cem. 1-18-2008 Lincoln Delaware 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bennie Smith FH-717 W. Division Rd Dover DE 23a. Part I, Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical o (or as a consequence of) Examiner teriose Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed the burial-transi and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Yea 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) signed by the al 1 ☐ Yes 2 ☐ No P.0. 9 ☐ Unknown 23e, Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown been si should I Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed? Yes 22 No certificate 2□ No 1 TYes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 R/Outpatient 3 DOA 2 🗆 No 1 | Inpatient Certification: To this ual or Atternary after the varial Director: After the varial Director: After the varial of the funers 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) e of death (Item 23a) (Type, Print) 111Am Date filed (Month, Day, 31 State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 1 2 1 - State Registra Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 9:34 AM M **Physician** Michael Ray Muir Sr. 29, 2008 January /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Barton 18917 Latrobe St. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. Jan. 28, 1940 9. Birthplace (State or Foreign 5 Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1XXM 2□F 68 Maryland 220-38-2331 Director Usual Residence of Decedent 10d. Inside City Limits death with the Marylend 10c. City, Town or Location 10a. State 10h Count r than "natural", or Items 23a or 28a-f show the Neglical Exampler must be notified at XXYes 2 No Barton Allegany MD Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21521 18917 Latrobe St. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. Specify: white 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes \$ No Specify: ð 3√√Vidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Charcoal Manufacturer College (1-4or 5+) other than Elementary/Secondary (0-12) Operator 12 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked othe any injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) Be Charlotte Beeman Sampson Muir ု 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 32 Centennial St., Frostburg, Maryland 21532 Michael R. Muir JR/ son 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 20a. Method of Disposition 02/01/ Mt. View Cemetery Barton, Maryland Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Boal Funeral Home 111 Church st., Westernport, Maryland 21562 Wan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Arteriosclerotic heart disease /Medical Due to (or as a consequence of): Examiner Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Carcinoma of the lung Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 20 No 1 ☐ Yes 2 ☐ No certificate 1 Yes or Attending Physicien: 24 hours after death.

Funeral Director: After this certific etely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification; To Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Yes 2□ No 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 27 Manner of Death Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, tactory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier D09157 Jan 29 2008 Paul Snew M. D. Wanne and address of person who completed P. D. Wanne and C. 10 32. Régistrar's Signature 31. Date tiled (Month, Day, Year) State JAN 3 1 2008 Registrar

08-00900 Walter T. Mattews

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryland	Denartment	of Health	and	Mental	Hvalen
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1	Physicia	n/	egistrar 1. Decedent's Name (First, Middle, Last) M	ate of Death Onth Day Year 1000 hrs		
Mé	Examir		VIVE TICE CHICAGO TO THE STATE OF THE STATE	4c. County of Death		
			4a. Pacility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. Spmers Cove Apts. Crisfield	Spmerset		
	F	4	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8.	Date of Birth(MM/DD/YYYY) 9. Birthplace (State or		
	Funeral Director		218-30-1393 12M 2 F 72 Yrs. Months Days Hours Min.	11-20-35 Foreign Country) Md		
	any	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits		
	* .	Funeral Director	MA Somerset Cristield	1 XYes 2 No		
10	larylar 28a-f s at on		10e. Street and Number 10f. Zip Code	10g, Citizen of What Country?		
01	the Ma or 2	盲	64 Somers Cove Apts. 21817	Yes or No- 14. Race - American Indian, Black,		
0	r death with the Maryland or items 23a or 28a-f show must be notified at once.	eral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Rica	1411.11		
-	or ite	Fun	Never married 2 Married 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No Specify:	Specify: Black		
	hours aften natural", Examiner	ò	or Dates: 15 Decedent's Education (Specify colly highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work	done 16b. Kind of Business/Industry		
	72 hou n "nat	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	S-Call		
5-0038	vithin 72 ene. er than Medical	Comple	6 Laborer	st, Middle, Maiden Surname)		
7	Hygi d oth	ပိ	Make State (1955)	Mae Taylor		
, ,	Menta marke	To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura			
٤	Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f short prother transmatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner.	-	Garaldine Jackson Cousin 299 Somers Cove Asts	ate 120c, Location - City or Town, State		
9	I and I healt fitem		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	ate 20c. Location'- City or Town, State		
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		_	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re-			
	ysician /Medical		failure. List only one cause on each line.	Death		
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		_	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):			
		nine	cause. Enter Underlying Cause			
	ed sit	Examiner	events resulting in death) Last Due to (or as a consequence of).			
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	by the arched	Ph	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✓ Unknown		
i	res tha signed be del	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part II. Yes 2 No 3 Z4a. Was an 24b. We autopsy performed? 1 Yes 2 No 1 Z4b. Was an 24b. We autopsy performed? 1 Yes 2 No 1 Z4b. Was an 24b. We autopsy performed? 1 Yes 2 No 1 Z4b. Was an 24b. We autopsy performed? 1 Yes 2 No 1 Z4b. Was an 24b. We autopsy performed? 1 Yes 2 No 1 Z4b. Was an 24b. We autopsy performed? 25. Was case referred to medical examiner? Z5b. Was case referred to medical examiner?				
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	Division of Vital Records, P.O. ra or Attending Physician: The law requires that the stated death. The alter death. "In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact.	Completed		1 ✓ Yes 2 No 1 ✓ Yes 2 No		
	al R ian: T ertific ctor, p	Be C	25. Was case referred to medical examiner? Hospital: 4 Inspital: 4			
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	n of ding I h : Afte : funer	ü.	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No			
	Aften Aften or deat rector by the	icati	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2	8f. Location (Street and Number or Rural Route Number, City		
	Div ital or rs after ral Div	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town, State)		
	Division of Vital Records, P.O. BOX 68/600, The Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and decomply one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time.	ue to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)		
	with Com	Med	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)		
			high his, more O.C.M.E.	February 2, 2008		
			30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			
		State	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Regi	stra	FEB 0 5 2008 Flow & Jane	OCME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 29c, 30 per dvr 98/6 2-7-08 vt State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Vinglia Vouglass /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 60 If Under 1 Year If Mod Gara If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 7 F Months Days 232105881 Director ROANOKE. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 ie marked other than "natural", or items 23a or 28a-f ehow other traumatic event, the Modical Examinar must be notified at 1 Yes 2 No Vakland Directo Garr 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 706E barrett Alder 273 2550 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give/ 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Modical Exemines once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Whife à Specify: 3 Ø Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MANAGER GIFT SHOP 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 HARRY WILLIAMS HUFF HARRIET BELL SNAPP 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LYNNE M. ELMLINGER 405 FAIRWAY DRIVE, OAKLAND MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 'would war Gift Morest 1-31-08 MORGANTOWN WV 26506 21. Signature of Funeral Service Licensee 22 Name and Address of Ficility WVUHUMAN GIFT REGISTRY MORGANTOWN WV 26506 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** non non ra disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the ettending physicien and compilerely filled in by the funeral director, page 2 should be detached for use as the burnarist compilerely filled in by the funeral director, page 2 should be detached for use as the burnari-transit ettending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ᡚ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day 4☐ Pregnant at time of death Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 TYes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ Xe 1 Dinpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To he best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 29c. License number D23979 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Robert Goralski 311 North 4th St. Oakland, Md. 21550 31. Date filed (Month, Day, Year) 32 negistrar's Signature State Registrar 2008 0

State of Maryland / Department of Health and Mental Hygiene 1 1 2

					,	Certificate of	f Death	R	ag. No.	JO	00400	
Physician /Medical Examiner			1. Decedent's Name (First, Middle, La	ast)				2. Date of Dear	th	Voca	3. Time of Death	
			Pall Alloughtin Nellman						Day y 25, 20	Year 008	10:00 p.m.	
			4a. Facility Name (If not institution, given	ve street and numbe	r)		4b. City, Town, or Lo		4c. County			
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	Funeral	To Be Completed by Funeral Director		Sex 7.7 1∭2 M 2□ F	Age (In yrs. last bii	Months Days		8. Date of Birth (Month, Day)	Year)	9. Birthpl	lace (State or Foreign try)	
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	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location				10	0d. Inside City Limits	
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	the 1		Maryland Washin	gton	H	agerstown 10f. Zip Code		1	0g. Citizen of W	hat Caunt		
	with pe or					101. 2ip code		'	og. Citizen of W	nat Count	пуг	
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21215-0020	be filed within 72 hours after death with the Maryland that Hygiene. do other than "netural", or items 23e or 28e-f ehow event, the Medical Examinat must be nutified at		15. Decedent's E	ducation	16a.	Decedent's Usual Occu	upation		16b. Kind of Bus	siness/Ind	lustry	
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Б	be file d oth event		17. Father's Name (First, Middle, Last,)			18. Mother's Name	(First, Middle, M	Maiden Surname	9)		
yla	should be filed vand Mental Hygies marked other i		Charles Edward N	ewman			Lillie '	Virginia	Thomps	on		
Maryland	2 sh and Is m		19a. Informant's Name/Relationship (19b	. Mailing Address (Stree	t and Number or Rura	Route Number	City or Town, S	State, Zip	Code)	
	and ealth n 27 ner tr		Shirley Shirey -	Niece	1	6627 Kendle	Road, Wil	lliamspo	rt, Md.	217	95	
ore	ges 1		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □	Removal from State		Disposition (Name of y, crematory or other pla	ace)	Date	20c. Location - (City or Tov	wn, State	
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Ball	permit. Pages 1 and 2 should b Department of Health and Menis Important: If item 27 Is marked any Injury or other treumatic e- once.		21. Signature of Funeral Service Liger	^		22. Name and Addr	ess of Facility Min	nich Fu	neral H	ome	<i></i>	
_	20 E # 9		James J. Sp	icer		415 E. Wi	lson Blvd.	Hagers	town, M	d. 2	1740	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	ed the death. Do r	not enter the mode of dy	ing, such as cardiac o	r respiretory arre	est,		Approximate Interval Between	
1	Physician		Onset and Death									
	/Medical Examiner		Immediate Cause (Final disease or condition									
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	and and II-trar		Sequentially list conditions, Due to (or as a consequence of):									
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	ysicl is cer direc		examiner? 1 Yes 2 100	Hospital: 1 ☐ Inpat	ient 2 ER/Qui	patient 3 DOA Oth	her: 4 / Wrsing Hon			(Specify))	
DIVISION OF	Attending Physiclen: or death. ector: After this certific by the funeral director.	Ë	27. Manne Death	28a. Date of Inj (Month, Da	ury 28b. T	ime of 28c. Inju		8d. Describe ho				
ĕ	aath. or: Af he fu	Certification:	2 ☐ Accident investigation		.,		Yes 2□No					
Ĕ	or Attencation after death Director:	≝∥	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	200. Flace Ul III	jury - At home, far tc. <i>(Specify)</i>	m, street, factory, office	2	8f. Location (Str. City or Town,		or Rural	Route Number,	
בֿ	tal or A rs after el Direc	Ç			(=====,)			0.0, 0	Olalo)			
	tospl 4 hou uner uner ely fil	edlcai	(Check only 2 Madical Exam	ysician: To the best	of my knowledge,	death occurred et the till Vor investigation, in my d	me, date and place, a	nd due to the ca	use(s) and man	ner as sta	ited.	
	To the Hospital or / within 24 hours after To the Funerel Dire completely filled in b		one)	and manner s	ated.							
	0 4 ki 5		29b. Signature and title of certifier		10	29c. Licens	- 3	29	d. Data signed	(Month, Di	ay, Year)	
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	3B		31. Date filed (Month, Day, Year)	- 40	730	mill	ST. HAG	ers wh	n, MD	011	40	
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P.O. Box 68760. Division of Vital Records, To the Hospital

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 2615 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 69 Wolt Yan Daniel M. S 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2008

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicai

State

Registrar

29a. Certifier

08-00336
Mark Lee O'Conno

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

.a. 200 0 0		1-For State Registrar Certificate of Death	and Mentarriy	Reg.	No. 200	8 0346			
Physic		Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death			
Medical Exan	niner	Hark Lee O Connor		Month D. January 12,		1526 hrs			
		St. Mary's Hospital St. Mary's Hospital Leonard	n, or Location of Death		4c. County of Death St. Mary's				
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1		8. Date of Birth (I	MM/DD/YYYY) g. Birt	hplace (State or			
Directo		215-94-3851 1X M 2 F 40 Yrs. Months Usual Residence of Decedent	Days Hours Min.	09/11/1	.967 Foreig	nTennessee			
any		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits							
Maryland 28a-f show	5	Maryland St. Mary's Great Mills							
Maryll 28a-f	Director	10e. Street and Number 10f. Zip Co	de	10g.	Citizen of What Cour	ntry?			
vith the Maryland s 23a or 28a-f show	Ä	20686 Ronnie Lane 20634			nited Stat				
0036 within 72 hours after death with the Maryland giene. Net than "matural", or items 23a or 28a-f she Makical Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify C	of Hispanic Origin? (Spe Suban, Mexican, Puerto F		14. Race - Ameri White, etc.	can Indian, Black,			
fter de	E.	1 Yes 2 X No 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X	No specify:		Specify: Wh:	ite			
ours at atural	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occ	Decedent's Usual Occupation (Give kind of work during most of working life. DO NOT use retired)		6b. Kind of Business/I				
6 n 72 h an "n	lete	Elementary/Secondary (0-12) College (1-4 or 5+)	g lile. DO NOT use retin	ed)					
withingiene.	Completed	12 Electrician 17. Father's Name (First, Middle, Last)	18.Mother's Name		Constructi	on			
AD 21215-0036 2 should be filed within 7 h and Mental Hygiene. 27 is marked other than	Be C	Frank O'Connor	Nellie Ma	,	acir carrente,				
213 ould b d Men s mar	10	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (3			er, City or Town, State	, Zip Code)			
MD Id 2 sho lith and m 27 is		Nellie M. Horton/Mother P.O. Box 46		ills, MD	20634				
ore, es l ar of Hez If itel		20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 20b. Place of Disposition (Name of crematory or other place)	of cemetery,	Date 2	20c. Location - City or	Town, State			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. The propertant: I them 27 is marked other than "natural", injury or other fraumatic years the Medical Evaniona.	5	4 Donation 5 Other Specify: Brinsfield-Echo.							
Balti permit. Departir Imports		21. Storage of Funeral Service tropsee 22. Name and Add Edward N. Brinsfield, Jr. M00052 22955 Ho	Bring Bring	nsfield :	Funeral Ho	me, P.A. D 20650			
Physicia	า	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of d	ying, such as cardiac or	respiratory arrest	, shock, or heart	Approximate Interval			
Medica		failure. List only one cause on each line. Immediate Cause (Final disease a. Cocaine intoxication Between Onset and Death							
amme	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Lest							
uted id	Ë	events resulting in death) Last Due to (or as a consequence of): d.							
760, ficate be executed by physician and the burial - transit	Medical	X UNPENDED ##23a_FII_27_28a_f. perME_g876, 2/11/08 TT							
760, icate be physically be build	/Me	1F FEMALE: 23c. if yes, outcome of pregnancy			23d. Date of delivery				
certification	cian	past 12 months? past 12 months? pregnant at time of death Other (Specify,	3 Ectopic pregnar	ncy	Month [Day Year			
O. Box 687 at the death certificated by the attending personal of by the attending personal the personal of the second of the se	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	/						
P.O.	by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying ca	use given in Part I.		acco use contribute to				
S, P.C uires that in signed I	ed b	Atherosclerotic cardiovascular disease		1 Yes 2 No 3 Probably 4 Unknown					
cords law requir	plet		24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?						
tal Rectian: The I	Completed			1 Y Yes 2		es 2 No			
Vital Rec ysician: The l his certificate	BB B	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other:							
n of Villing Physic	-	1 Yes 2 No I Inpatient 2 Levodipatient 3 Don		28d. Describe how		r.			
Sion C Attending death. ector: Af		Natural 5 Pending Find 1/12/2009 Find 2.45 pm 1	Yes 2 X No	unk					
Division of Vital Records, tal or Attending Physician: The law require is after death. After this certificate has been sized in by the fineral director mase 2 should it.	iji e	2 Accident Investigation 3 Suicide 6 X Could not be Accident Investigation Suicide 1	fice building, etc.	28f. Location (Str		ural Route Number, City			
Di Spital Jours a Jeral P	28a. Date of Injury - At home, farm, street, factory, office building, etc. 28a. Date of Injury - At home, farm, street, factory, office building, etc. 28b. Place of Injury - At home, farm, street, factory, office building, etc. 28c. Place of Injury - At home, farm, street, factory, office building, etc. 28c. Place of Injury - At home, farm, street, factory, office building, etc. 28c. Place of Injury - At home, farm, street, factory, office building, etc. 28c. Place of Injury - At home, farm, street, factory, office building, etc. 28c. Place of Injury - At home, farm, street, factory, office building, etc. 28c. Place of Injury - At home, farm, street, factory, office building, etc. 28c. Place of Injury - At home, farm, street, factory, office building, etc. 28c. Place of Injury - At home, farm, street, factory, office building, etc. 28c. Place of Injury - At home, farm, street, factory, office building, etc. 28c. Place of Injury - At home, farm, street, factory, office building, etc. 28c. Place of Injury - At home, farm, street, factory, office building, etc. 28c. Place of Injury - At home, farm, street, factory, office building, etc. 28c. Place of Injury - At home, farm, street, factory, office building, etc. 28c. Place of Injury - At home, farm, street, factory, office building, etc. 28c. Place of Injury - At home, farm, street, factory, office building, etc. 28c. Place of Injury - At home, farm, street, factory, office building, etc. 28c. Place of Injury - At home, farm, street, factory, office building, etc. 28c. Place of Injury - At home, farm, street, factory, office building, etc. 28c. Place of Injury - At home, farm, street, factory, office building, etc. 28c. Place of Injury - At home, farm, street, factory, office building, etc. 28c. Place of Injury - At home, farm, street, factory, office building, etc. 28c. Place of Injury - At home, farm, street, factory, office building, etc. 28c. Place of Injury - At home, farm, street, factory, office building, etc. 28c. Place of Injury					nardtown, MD			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici promisely elified in but the finneral director mass 2 should be detached for use as the burit.	ledical	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
FSFS	≥ 29b. Signature and title of certifier 29d. Date s					nth, Day, Year)			
	· ·				January 13, 200	8			
		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Bal	timore, MD 21201						
Regi	State strar	31. Date fijed (Magih, Day, Year) 32. Registrar's Signature							
			· · · · · · · · · · · · · · · · · · ·						

ORIGINAL

			1 - For State Registrar	State	of Mary	yland / Depa <i>Cer</i>	artment of H	leaith a <i>Death</i>	ind Me		iene () (8	034	69
			Decedent's Name (First, Middle, La	· · · · · · · · · · · · · · · · · · ·		2. Date of Death	ath 3. Time of D			Death				
	Physici		Roy	ctor, Sr.			January	7 29 2008 (0613	Α ^M			
1	/Medic Examin	_	4a. Facility Name (If not institution, gi	4b. City, Town, o	or Location of		Juliuary	4c. County		0013				
	Examin	er	76 Crouse Lane	E1ktoi				Cec						
	Funanal									8. Date of Birth		9. Birtho	place (State o	r Foreign
	Funeral Director	153-14-1566 ¹™ 2□F 92 Yrs.					Months Days	Hours	Min.	Month, Day, June 20,	1915	Cour	Jerse	_
	*	ł	Usual Residence of Decedent		1 12					June 20,	1713	11011	OCIDO	·
	ylang		10a. State 10b. County		10	Oc. City, Town or Lo	cation					1	IOd. Inside Ci	ty Limits
	Mar.	tor	Maryland Cecil			E1kton							1 🗌 Yes	2 X No
	r 282	Director	10e. Street and Number				10f. Zip Code			10	Og. Citizen of W	hat Cou	ntry?	
	h wit	D D	121 Brewster Br	idge Ro	oad		2192	1	1			United States		
	deat	ner	11. Marital Status	12. Was De	cedent Eve	r in U.S. 13.	Was Decedent of H	lispanic Orig	gin? (Spec	cify Yes or No-			can Indian,	
9	or its	3	1 Never Married 2 Married		2 ሺ No		1 □ Yes 2 🎇 No		, r delto r	tican, etc.)		k, White,	BIG.	
က္က	ral',	by	3 Midowed 4 ☐ Divorced	Year or	Dates:			эрвспу.			Specify.	Whi	te	
S O	within 72 hours after death with the Maryland ene. Then "natural", or iteme 28a or 28a-f ehow ha Madical Examinar natal be malified at	Completed by Funeral	15. Decedent's E (Specify only highest gi	ducation ade completed	()	(Give	dent's Usual Occup kind of work done	during most	of workin	ng .	16b. Kind of Bu	siness/In	dustry	
7	ithin	dr dr	Elementary/Secondary (0-12)		(1-4or 5+)	life. I	DO NOT use retire	d) 						
7	ygier yertt	Ö	12			Me	chanical				Aero		e	
pu	tal H d off	Be	17. Father's Name (First, Middle, Las	"						(First, Middle, N	Maiden Sumami	e <i>)</i>		
<u>×</u>	Men Men Marke	၉	Joseph Proctor							Howe				
Jar	2 sh and le m	9 3	19a. Informant's Name/Relationship				ng Address (Street					State, Zip	Code)	
<u>~</u>	and lealth m 27 her t	(3)	Janice Forlano	Daughte			rouse Lai			_		City on T	Chata	
0	ges 1 t of t if Ite or ot		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 [Removal fron	II State	20b. Place of Dispo cemetery, crer		100	anuar	y 31,	20c. Location -	City of To	own, State	
Ë	tant:	١.,	4 □Donation 5 □ Other (Spec		}.	R. A. Ferri			800		West Ch	este	er, PA	
Baltimore, Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Deportment of Health Hygiene. Deportment Hygiene. Deportment Hygiene.		21. Signature of Funeral Service Lice	nsee			Name and Addre			rale P	Δ			
_	<u>~</u> 0 = • 0	7 3	Donald	3. Alex	ha		icks Home 03 W. Sto					1921		
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that one cause on	caused the each line.	e death. Do not ent	er the mode of dyi	ng, such as o	cardiac or	respiratory arre	est,		Approximat Interval Bet Onset and I	ween
	Physician		Immediate Cause (Final disease or condition	a	(AX							Onset and I	300,11
	/Medical Examiner		resulting in death)	Due to	o (or as a c	onsequence of):								
	Examine		Sequentially list conditions,	b										
	pe is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	onsequence of):										
V	and trans	cam	that initiated events resulting in death) Last	C. Due to	. /	onsequence of);						_		
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9 ×	n certific anding p use as	/Me	IF FEMALE:	23c. If yes, o	utcoma of	aroananau								100000
Вох	eath certif ettending for use a	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1□Live	birth 2	Fetal death 3	Ectopic pregnanc	у			23d. Dat Mor	e of deliv nth	,	Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unk	gnant at tim nown	ie oi death 5	Other (specify) _							
<u>α</u>	that the de led by the e detached f	F	Part II. Other significant conditions	contributing to	death but r	not resulting in the u	nderlying cause giv	ven in Part I.		23e. Did tob	acco use contr	ibute to t	the cause of c	leath?
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<u>e</u>	pag pag											Yes	2 11 No	-
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ot	Physician: rthis certific ral director,	2	1 Yes 2 Namer of Death	1L	Inpatient	2 ER/Outpatier 28b. Time of	IL SLI DOA	4 🗆 Nui		ne 5 Reside	- 1		Resid	ence
5	Jing After fune	5	Natural 5 ☐ Pending		e of Injury onth, Day Y	ear) Injury	Wo	rk?]Yes 2⊟1		.ou. Describe no	Williamy occur	60		
Si	Attending r death. ector: After	cat	2 Accident investigation 3 Suicide 6 Could not	De Gla	ce of Injuny	- At home, farm, str		, 183 2		8f. Location (St.	reat and Numb	ar or Rur	al Boute Nur	phar
Division of Vital Records,	or Attendent efter deatl Director: I in by the	Certification;	4 Homicide determine	buil	ding, etc. (Specify)	eet, ractory, onles			City or Town	, State)	o, o, ,,,,,,	u.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	50.,
	Hospitel		29a, Certifier 1/9 Certifying F	hysician: To the	ne best of n	ny knowledge, deat	h occurred at the ti	me date and	d place, a	and due to the ca	ause(s) and ma	nner as s	stated	
	Hospit 24 hours Funera eteky fille	edical	(Check only 2 Medical Exa	miner: On the	basis of ex	amination and/or in	vestigation, in my	opinion, deat	th occurre	ed at the time, da	ate and place, a	and due	to the cause(s	;)
	To the Hospitel or Attent within 24 hours efter death To the Funeral Director: completely filled in by the	Me	29b. Signature and title of Sentifier	7			29c. Licens	se number		2	9d. Date signed	(Month,	Day, Year)	
	- 5 F ö		* d	7		, N	al as	OSL	CIC	19	1/30	105	?	
	4		30. Name and address of person who	completed ca	use of deat	th (Item 23a) (Turk	Print	1			1100	1	J	
	0	1	oloria Simon	Ga Mi	5 //	West	Holas	7. Si	I	e 307	EK	-	MA	1921
	Sta	te	31. Date filed (Month, Day, Year)	32.	Registrar's	Signature	17			- 0-0		יייע	1,10	177
	Registi		FFR - 7 200	3 1000	Sind A	or sound	2							

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Day Year Bernard Eugene Purcell Month 11:10 A M 28,_ January 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 1**⊠**M 2□F Days 220-42-4671 Yrs Director 67 April 29,1940 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland St. Mary's Drayden 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or dkal Examiner must be r 46640 Purcell Farm Lane 20630 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White ģ 3 Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Exxon Mobile al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Gas Company 12 Tanker Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental H Be George T. Purcell ဥ Lillian Marie Dyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other tra P.O. Box 92 Great Mills, MD 20634 Diane M. Purcell / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State January 31, St. George Cemetery 4 Donation 5 Dother (Specify) Valley Lee, Maryland 2008 Signature of Funeral Service Licenses 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P P.O. Box 270 Leonardtown, MD 20650 and 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consi Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed ed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð as been signal by 2 should by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page certificate 1∐ Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ■ ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director; After th 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner/stated. 29a. Certifier Medical (Check only within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) of death (Item 23a) Type, Print) 30. Name and address of person who completed James P. Jarboe, M.D. 24035 Three Notch Road Hollywood, MD 20636 31. Date filed (Month Day, Year) gistrar's Signature

DHMH 17 Rev 1/2001

Registra

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Vear **Physician** 25, 2008 8:15 p January Teresa Picard /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayside Care Center Lexington Park St. Mary's 8. Date of Birth (Month, Day, Year) (State or Foreign 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Days Months Hours 1 □ M 2 💢 F Director 031-18-1880 81 04/30/1926 Massachusetts Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 21 No Director Maryland | St. Mary's Lexington Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21895 Pegg Road 20653 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Maryland 21215-0036 Specify: 3 XWidowed 4 ☐ Divorced 'natural', White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) Clerk 8 Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event Be Maria Consiglio Donato Garofoli 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20877 Ark Court, Lexington Park, MD Harvey P. Picard, Jr./Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Brinsfield-Echols Cre 01/28/2008 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) Sign uneral Service Edward N. Bri 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signal Brinsfield, M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Denne Diseus a EN a Immediate Cause (Final disease or condition STACE TRANS **Physiclan** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the sequence (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed and Due to (or as a consequence of): Records, P.O. Box 68760, physician Physician/Medical the as attending plant for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 certificate 1□ Yes 2 1 No Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death Check onl one Be Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 734178 28/09

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State Registrar David M. Federle,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yeer **Physician** Month 0125 Ralph Donald Rogers JANUARY 15, 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sardy Spring Montgomery Brooke Grove Kelhabi litationard Nursing Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Nonths Days Hours Min. Aug. 20, 1914 Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Michigan Yrs. Director 578-32-2373 93 Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow the Mudical Examiner must be notified at 1 Yes 2 □ No Directo Sandy Spring Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 238 18131 Slade School Road 20860 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: "naturel", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coflege (1-4or 5+) permit. Pages 1 end 2 should be flied v. Depertment of Health and Mental Hygier important: if item 27 ie marked other tt any Injury or other traumatic event, IIIa 000.8. 1 Accountant Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ralph Edwin Estella Sleesman Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3009 Gold Mine Rd., Brookeville, MD 20833 <u>Marcia Collie/Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 1/23/08 Falls Church, VA 21. Signature of Fun ral Service Lipe 22. Name and Address of Facility Affordable Funeral Service 7482 Lee Highway, Falls Church VA 22042 East the disease se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Physician a. hypernatremic delydration Due to (or as a consequence of): days /Medical Examiner , metastatie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9□ Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ artery disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 分Unknown with Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 2 No 1 Yes 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of fnjury 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 Pending investigation within 24 hours efter death.

To the Funeral Director; All completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier the s 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D42046 The Staff January 15, 2008 Physician 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Grace Brooke Hoffman. Spring, Maryland 20860 M.D. 18100 Stade School Road Sardy 31. Date filed (Month, Day, Year)

JAN 2 4 2008 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene UU0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February **Physician** Delphia Romine 2008 4:25 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Examiner Northampton Manor Health Care Center Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 2, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Min. Months Hours 410-12-6361 Alabama Jan. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be noritinal anone. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits XX Yes 2 No Williamson Director Tennesseel Brentwood 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 305 Hayeswood Drive 37027 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Alo No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XX No Specify: specifi White à XX Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Service Rep., Manager Telephone Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charlie H. Vicars Maggie Mills ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Cheryl Moore, niece 5315 Saint Mawes Court, Frederick, MD 21703 20b. Place of Disposition (Name of cemetery, crematory or other place)
Romine Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Feb 5, 2008 Rogersville, Alabama 4 □ Donation 5 □ Other (Specify) 21. Signature of Fuheral Service Licensee ²²Keeney and Basford PA Funeral Home MO0255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one of use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEAR. DISEASE IAL VULAR **Physician** /Medical Due to (or as a consequence of): **Examiner** ULMONAR if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-tran Due to (or as a consequence of) Physician/Medical the attending ph for use as t IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 ☐ Unknown signed b I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 202 No 1 Tyes 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 □ Yes 2 No 2□ No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A

3altimore, Maryland 21215-0036

(Check only

Medical

State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated 29b. Signature and little of certifier Illu

29c. License number D 47951

29d. Date signed (Month, Day, Year)

February 2, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D., 814 Tol 814 Tollhouse Ave., Frederick, Maryland 21701 Sibte Α. Kazmi, 31. Date filed (Month, Day, Year)

2008

D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 9:15 A.M John Paul Rakowski /Medical January 31. 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8504 Hollow Rd. Middletown Frederick 6. Sex M 2□F Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 069-18-8520 83 Director 1924, Nov. 26 New York Usual Residence of Decedent 10c. City, Town or Location show 10a. State 10d. Inside City Limits an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at 1 ☐ Yes 2. No Director Md. Frederick Middletown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8504 Hollow Rd. 21769 U.S.Adeath v Funeral 12. Was Decedent Ever in U.S. Armed Forces?

Y☐ Yes 2☐ No If Yes, Give Year or Dates:

41-14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 41-46 1 ☐ Yes 🏖 No Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the Operating Engineer 12 Machinaru permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Rakowski UnKnown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8504 Hollow Rd. Middletown, Md. Barbara A. Kendall (Daughter) 21769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithshurg Crematory Smithsburg, Md. 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg, Mc. 21783 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Obstructive Pulmonary hronic 10 years Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of) Examine sician and burial-transit the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician the detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records. 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy 1□ Yes 2 No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 270 10 P 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FEB

wer

James L.

- 7 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

coessier mo

32. Registrar's Signature

29c. License number

D 20488 - MD

POBOX 20 MIDDLETOWN, MD. 21769

29d. Date signed (Month, Day, Year)

Registrar

400 W. Seventh St.

Frederick, MD 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WADHWA

32. Registrar's Signature

CAKHVINDER

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month SOPHIE ${\tt A}^{\sf M}$ SHEPEL January 26, 2008 3:45 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Frederick Memorial Hospital Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Days Hours 1 M 2 TF Months 199-12-8407 5/10/1923 84 Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No MD Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7321 Ridge Road 21702 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XOXNo Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Technician 12 Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rade Dmitrovich Lenka Trenc 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of StElijah Serbian Orthodox Cemetery 1/31/2008 Aliquippa.Pa.15001

22. Name and Address of Facility

Mastrofrancesco FuneralHome

Aliquippa,Pa.15001 Marlene Powell (Daughter) 19330 Bettys Ave. Boonsboro, Md. 21713 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State 21. Signature of Funeral Service Licensee David & Mister MG1035 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause pn each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): 10mm 1-enc Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2F1100 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1-Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Physician /Medical Examiner Examiner and Physician/Medical

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

Completed by

Be 2

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 23a or 28a-f shov amy julyor or other traummette event, the Medical Examiner must be notified at any julyor or other traumatic event, the Medical Examiner must be notified at

attending physician detached for the signed by been s has this certificate

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The law requires that the death certificate be executed Records, 9 Completed or Attending Physician: Be ၉ Certification: Division To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by

OH-4

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

DR, CASDER 31. Date filed (Month, Day, Year) Cline

JAN 2 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

300 32. Registrar's Signature

MD

94h St

🗤 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Fred miD.

29d. Date signed (Month, Day, Year)

21701

ORIGINAL

DHMH 17 Rev 1/2001

completely

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 5:35 A M 2008 SONNENLEITER February **IRENE** GLADYS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Somerset Crisfield Alice Byrd Tawes Nursing Home Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Davs Hours 1 □ M 2 🕅 F Yrs. 99 Feb. 11, Maryland 212-05-1651 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 T\$Yes 2 No Crisfield Director Maryland Somerset 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 21817 6 Tawes Drive Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 2 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Telephone Company Operator/Supervisor 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Louise Jones John N. Jones 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Tawes Drive - Crisfield, MD Mamie Gargan (Sister) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/4/08 Chance, MD Rock Creek Cemetery 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, 21. Sign. u of Funeral Service grisee :

Gredory C. Sterling : 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transi attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 2 ☐ Fetal death 3 ☐Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) been signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 1☐ Yes After this certificate or Attending Physician: 26. Place of Death (Check only one) director. 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No Medical Certification: To 1 Inpatient 28d. Describe how injury occurred funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death filled in by the 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide within 24 hours at To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Usie Mighuns 201 CHACL Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

	4	For State Registrar	State of Maryland / De	epartment of H Certificate of L		Reg	ene2008	0347	
Physicia /Medica	n	Decedent's Name (First, Middle, Last) Donna	Marie Schweizer			2. Date of Death Month January	Day Year 2008	3. Time of Death 1653 P	
Examine	er	4a. Facility Name (If not institution, give s	treet and number)	3.	Location of Death		4c. County of Death		
		Union Hospital 5. Social Security Number 6. Sex	7. Age (In yrs. last birthd	Elkton		8. Date of Birth	Cecil	place (State or Fore	
rector	-	-	M 2 X F 50 Yrs	Months Days	Hours Min.	(Month, Day, Y March 4,	1957 West	t Virgini	
Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once,	o	10a. State 10b. County Maryland Cecil	10c. City, Town o					10d. Inside City Lin 1 ☐ Yes 2 🛣	
notif	Director	Maryland Cecil 10e. Street and Number	Elktor	10f. Zip Code		10g	. Citizen of What Cou	intry?	
st be		1 Elma Drive		21921			United S	tates	
ems er mu	Funeral		12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp In, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Amer Black, White		
or it	by Fi	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 【 No If Yes, Give Year or Dates:	1 ☐ Yes 2 🛣 No	Specify:		Specify:		
itural sal Ex			16a De	ecedent's Usual Occup	ation	16	W \(\Omega\): (ib. Kind of Business/li	ite ndustry	
Medic	plet	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	Give kind of work done of the DO NOT use retired	during most of work)	ring		•	
er tha	Completed	12		Vaitress			Restauran	t	
d oth	Be	17. Father's Name (First, Middle, Last)				e (First, Middle, Ma	iden Surname)		
narke	၉	Willard Tichnell				Taylor			
7 Is n traun		19a. Informant's Name/Relationship (Typ		Mailing Address (Street			City or Town, State, Z	ip Code)	
other		Keith G. Schweize 20a. Method of Disposition	20b. Place of D	Ima Dr., E1	;	Date 20	c. Location - City or 1	own, State	
y or o		1 M Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emovar nom state Immacul	crematory or other place ate	10000	ary 1,	Cherry Hil	1 MD	
oortar Injur	-	21. Signature of Funeral Service License	- Concept	ion Cemete 22. Name and Addres				1, MD	
any one		January &	Huko	22. Name and Addres Hicks Home 103 W. Sto	for Fune ckton St.	erals, P. <i>E</i>	A. - MD 21921		
		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death. Do not	t enter the mode of dyin	g, such as cardiac	or respiratory arres	t,	Approximate Interval Between	
<u>@</u> = .	cal Examiner	Sequentially list conditions, if any, leading to financially cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	20002					
2 m	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	,	23d. Date of delivery Month Day				
~ ×	by P	Part II Other significant conditions con	II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did toba						
be q						1 ☐ Yes	2/2 No 3 □ Pro		
ate has been signer bage 2 should be d				o didonying oddoo giv		24a. Was an autopsy performe	24b. Were au	topsy findings avail	
ate has been signer bage 2 should be d	Be Completed b	25. Was case referred to medical examiner?				24a. Was an autopsy performe	24b. Were au prior to c death?	topsy findings avail	
this certificate has been signeral director, page 2 should be d	To Be Completed	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 ☑ inpatient 2 □ ER/Outpa	atient 3□ DOA Oth	er: 4 Nursing H	24a. Was an autopsy performe 1 Yes 2 th (Check only one)	24b. Were au prior to c death? 1 □ Yes	obably 4 Unkn topsy findings avail ompletion of cause 2 No	
ffer this certificate has been signe ineral director, page 2 should be d	To Be Completed	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year) 28b. Tim Inju	atient 3 DOA Oth	er: 4 Nursing H	24a. Was an autopsy performe 1 Yes 25th (Check only one) ome 5 Residen 28d. Describe how	24b. Were au prior to c death? 1 Yes	obably 4 Unkn topsy findings avail completion of cause 2 No	
ifer this certificate has been signer ineral director, page 2 should be d	Be Completed	25. Was case referred to medical examiner? 1 Yes 2 No F	28a. Date of Injury 28b. Tim	atient 3 DOA Oth	er: 4□ Nursing Hey y at k?	24a. Was an autopsy performe 1 Yes 25th (Check only one) ome 5 Residen 28d. Describe how	24b. Were au prior to c death? 1 Yes	obably 4 Unkn topsy findings avail completion of cause 2 No	
ifer this certificate has been signer ineral director, page 2 should be d	Certification: To Be Completed	25. Was case referred to medical examiner? 1 Yes 2 No F 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide determined 29a. Certifier 1 Sertifying Physical Property 1 Certifying Physical Phy	28a. Date of Injury (Month, Day Year) 28b. Tin Inju 28e. Place of injury - At home, farm	atient 3 DOA Oth ne of 28c. Injury M 1 not not not not not not not not not not	er: 4 Nursing H y at k? Yes 2 No	24a. Was an autopsy performe 1 Yes 25th (Check only one) ome 5 Residen 28d. Describe how 28f. Location (Stree City or Town,	24b. Were au prior to c death? 2 No 1 Yes ce 6 Other (Spectrinjury occurred state)	topsy findings avail completion of cause 2 \(\sum \text{No} \) No and Route Number, stated.	
he Funeral Director: After this certificate has been signer pietely filled in by the funeral director, page 2 should be d	To Be Completed	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only 2 Medical Examiner)	28a. Date of Injury (Month, Day Year) 28b. Tini 28e. Place of injury - At home, farm building, etc. (Specify) sician: To the best of my knowledge, coner: On the basis of examination and/	atient 3 DOA Oth ne of 28c. Injury M 1 not not not not not not not not not not	er: 4 Nursing H y at k? Yes 2 No me, date and place	24a. Was an autopsy performe 1 Yes 25th (Check only one) 28d. Describe how 28f. Location (Stree City or Town, and due to the caurred at the time, dat	24b. Were au prior to c death? 2 No 1 Yes ce 6 Other (Spectrinjury occurred state)	topsy findings avail completion of cause 2 \(\sum \text{No} \) No and Route Number, stated. to the cause(s)	
ifter this certificate has been signer ineral director, page 2 should be d	edical Certification: To Be Completed	25. Was case referred to medical examiner? Yes 2 No F 27. Manner of Death Notural 5 Pending investigation 3 Suicide 4 Homicide Could not be determined 29a. Certifier (Check only one) 1 Certifying Physical Examination	28a. Date of Injury (Month, Day Year) 28b. Tini 28e. Place of injury - At home, farm building, etc. (Specify) sician: To the best of my knowledge, coner: On the basis of examination and/	atient 3 DOA Oth ne of 28c. Injury Mor 1 not not not not not not not not not not	er: 4 Nursing H y at k? Yes 2 No me, date and place	24a. Was an autopsy performe 1 Yes 25th (Check only one) 28d. Describe how 28f. Location (Stree City or Town, and due to the caurred at the time, dat	24b. Were au prior to c death? 2 No 1 Yes ce 6 Other (Spectrinjury occurred limits and Number or Rustate) sets and manner as the and place, and due	topsy findings avail completion of cause 2 \(\sum \text{No} \) No and Route Number, stated. to the cause(s)	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 6:30aH 23, Therese Sterling Jan. 2008 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick 4311 Rolling Acres Court Mount Airy If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days untry) Wash., 1 □ M 2 🔀 F 48 Yrs. D.C. Sep. 20,1959 579-94-7218 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a.***—any injury or other traumatic event, the Medical Property of other traumatic event, the Medical Property of other traumatic event, the Medical Property of other traumatic event, the Medical Property of other traumatic event, the Medical Property of Other Prop 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 🕅 No Maryland Frederick Mount Airy Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 4311 Rolling Acres Court 21771 Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forceş? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 🗓 No Specify: þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Co-op Grocery Store Accounting 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Salb Ruth Archambault မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) / Mother 415 Russell Ave. #709 Gaithersburg,MD 20877 Ruth Salb 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition January 23 2008 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Metropolitan Crematory Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Adenocarcinoma Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner be executed burial-tran and Due to (or as a consequence of): attending physician for use as the buria IF FEMALE: 23c. If ves. outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2 Fetal death 3 □Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Ö 9☐Unknown 9 ☐ Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 2 No , page 1□ Yes certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one funeral director Be Other: 4 Nursing Home 5 Nursing Home 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 🔲 Inpatient Certification: To this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death neral Director: After filled in by the funeral Injury (Month, Day Year) or Attending 5 ☐ Pending investigation 1 🕅 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Hospital 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 Jan. 23, 2008 MD22075 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shakun Malik, M.D. 3800 Réservior Rd., N.W. Wash., D.C. 20007 32 egis rar's Signature 31. Date filed (Month, Day, Year) State JAN 24 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Daniel Schwartz 5:55 aM January 19, 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 4, 1919 Birthplace (State or Foreign Country) **Funeral** Hours Days Months 1⊠M 2□F Min. Director New York 88 May 4, 061-14-4783 Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 419 Vierling Drive 20904 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after of Hygiene.
Hygiene.
ther than "natural", or Itel 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No þ Specify. 3 ☐ Widowed 4 ☐ Divorced Caucasian Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Federal Government 2 should be filed vand Mental Hygie is marked other i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Leon Schwartz Pauline Wallach 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is no any injury or other traum Bertha K. Schwartz - Wife 419 Vierling Drive, Silver Spring, Maryland 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 01/21/2008 Olney, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 2/2 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Renal Failure /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit Due to (or as a consequence of): the attending physician Physician/Medical as the l IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform 2⊠No To the Hospital or Attending Physician: within 24 hours after death. funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 □ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

Division or Vital Records, P.O. Box 68760

State Registrar

29b. Signature and title of certifie

Robert Kirkcaldy, M.D., 18101 Prince Philip Drive, Olney, Maryland 20832 31. Date filed (Month, Day, Year)

JAN 2 4 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

D0061681

29d. Date signed (Month, Day, Year)

January 19, 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 12:19 AM 2008 28 Patricia Stirling January Ann /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's St. Mary's Hospital Leonardtown Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 ☐ M 2 🖾 F 12/29/1954 53 Washington, DC Director 220-62-7584 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland St. Mary's Great Mills 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20634 22514 Iverson Drive Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Maryland 21215-0036 Specify. Specify: Completed by White 3 ☐ Widowed 4 ₺ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill Health and Mental H tem 27 is marked oth Be Sandridge Northern Shirley J. George ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27343 Harpers Ct., Mechanicsville, MD 20659 James R. Stirling/ Son If Item 27 or other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Grd. 2/1/2008 Leonardtown, Maryland 22. Name and Address of Facility
Brinsfield-Echols Funeral Home, P.A.
30195 Three Notch Rd., Charlotte Hall, 21. Signature of Funeral Service Licenses MD 20622 -M00817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Tuachial nauwounh **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Nocle. mass Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): Examiner Hypertersion physician and s the burial-trans Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) Ö 9□Unknown 9 Unknown مَ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1 Yes 2 No Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 TNo 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA P ō 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After Division **₩**Natural 5 Pending investigation 1 TYes 2 TNo 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 1 Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD mo D60888 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rakhi Krishnan Box 664 cheonardtown MD 20650 P.O. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2 2008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 22, 10:05 PM January 2008 Luigi Giovanni Sirtori /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3337 Gold Mine Road Brookeville Montgomery If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year Mar. 26, 1 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1XM 2□F Ĩ937 Italy 70 Director 584-38-2337 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes X No Director Great Falls VA Fairfax 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 22066 1127 Walker Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 Notes: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telecommunications Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maria Maggioni Adrianno Sirtori 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1127 Walker Road Great Falls, VA Nelly Sirtori/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/24/08 Chesapeake Crematory Beltsville, MD 4 □ Donation 5 □ Other (Specify) Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service License Ne MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** years Metastatic Pancreatic Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? 1☐ Yes 2☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2X No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 No 1☐ Yes 2∏ No 1 Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specifyhome Hospital: 2[X] No 1 🔲 Inpatient 1 TYes 2 ER/Outpatient 3 DOA 2 funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? al or Attending P s after death. Il Director: After i Certification: 1 X Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Chuke Ke January 23, 2008

Division or Vital Records, P.O. Box 68760,

18111 Prince Philip Dr. #327 Olney, MD 20832 Chitra Rajagopal, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 2 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

D42452

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year anuary Marie Schuhmann Scott /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Washington County Hospital Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthdav) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🗓 F 83 Director Dec 28 1924 Pennsylvania 162-28-6506 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2X No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13159 Little Hayden Circle 21742 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐No Specify: White Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Personal Residence Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward William Schuhmann Grace Pangle Schuhmann ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8124 Pete Wiles Road Middletown Maryland 21769 Mary H. Scott - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 1-29-2008 Hagerstown Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Meterkhi disease or condition resulting in death) Y COV /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and Due to (or as a consequence of): ttending physician Physician/Medical as 1 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Hospital or Attending Physician; The law requires that the death cartificate be executed Division or Vital Records, P.O. Box 68760, signed by t d be detach After this 24 hours after death e Funeral Director:

within 24

Baltimore, Maryland 21215-0036

29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

41667

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

McCorneck chael

31. Date filed (Month, Day, Year)

32. Registrar's Signature



DHMH 17 Rev 1/2001

Medical

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 24a, b, 25 per drog 876, 02/19/08dhb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** HERMAN ALVIN TREGO JR. 1/19/2008 8:35 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **KENT** ROCK HALL 5648 BOUNDARY AVE Social Security Number If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Months Min. 1**X** M 2□ F Days Hours Director 12/26/1948 MD 216-54-8891 the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f show notified at 10b. County 1 X Yes 2 □ No Director MD KENT ROCK HALL 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or Items 23a or the Medical Examiner must be USA 5648 BOUNDARY AVE 21661 death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 MYes 2 □ No If Yes, Give Year or Dates: **VIETNAM** 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) IT SYSTEMS ADMIN TECHNOLOGY 12 traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HERMAN A. TREGO, SR. FLORENCE M. COLEMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a Department of Health Important: If item 27 any Injury or other tr once. MELANIE TREGO/WIFE PO BOX 71 ROCK HALL, MD 21661 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State CHESAPEAKE CREAMATION 1/28/2008 | STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 prentellar Approximate Interval Between Onset and Death 23a. Rart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner he law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical the nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 TUnknown cale has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼No 24a. Was an autopsy perforn 2 No or Vital the Hospital or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Medical Certification: 28c. Injury at To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After Division 5 ☐ Pending investigation Natural Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of c 29c. License number rtifier 29d. Date signed (Month, Day, Year)

Registrar

State

Name and address of person who completed cause

JAN 2 3

32. Regis

2008

31. Date filed (Month, Day, Year)

08-00776 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. William Royston Troyer, Jr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ Date of Death Month **Medical Examiner** 1210 hrs William Royston Troyer, Jr. January 28, 2008 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 1902 Eden Mill Road Pylesville Harford 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of 8irth(MM/DD/YYYY) 9. 8irthplace (State or Foreign Country/MD Months Days Hours Director 1 XM 2 F 53 Yrs 217-64-3414 1954 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show Yes 2 X No Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, <u>the Medical Examiner must be notified at once.</u> MT Harford Pylesville hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2201 Telegraph Road 21132 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, 8lack Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 2 X No Yes Widowed Divorce Yes, Give Year Specify: White Yes 2 X No specify: <u>چ</u> Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) timore, MD 21215-0036

Pages 1 and 2 should be filed within 72 I trent of Health and Mental Hygiene. College (1-4 or 5+) Self Employed Logging 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Royston Troyer, Sr. Maria Hoeckmeyer ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2201 Telegraph Road; Pylesville, MD 21132 Patricia J. Troyer/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Feb. 4, 2008 1cKendree Cemetery White Hall, MD 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
1.J. Hartenstein Mortuary, Inc. (<u>3</u>) DVR) (per S. Main St. Stewartstown, PA James J. Hartenstein, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line 8etween Onset and /Medical Death a. Torso Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Discussion injury that initiated events resulting in death) Last Due to (or as a consequence of) transi and Physician/Medical X AMENDED UNPENDED the attending physician ed for use as the burial per FD G904 6/1/10 TT The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown this certificate has been signed by the director, page 2 should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No ✓ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 Yes 28a. Date of Injury FOUND: FOUND 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred

Hospital or Attending Physician: funeral After To the Hospital or within 24 hours after death.

To the Funeral Director: A the Funeral Director: A neral Director: /

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie

Pending

Investigation

Could not be

determined

29c. License number O.C.M.E.

1 ✓ Yes 2 No

29d. Date signed (Month, Day, Year) January 29, 2008

28f. Location (Street and Number or Rural Route Number, City

Tree struck subject

or Town, State) 1902 Eden Mill Road, Pylesville, MD

30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD

Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201

FOUND:

1125 hrs

28e. Place of Injury - At home, farm, street, factory, office building, etc

State Registra

Certification:

Medical

3

Natural

Suicide

Homicide 29a. Certifier 1

2 🗸 Accident

Jan 28, 2008

(Specify) Woods

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Tudy Eynn Wojcik
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INIC OINIC		State of Maryland / Dep	ertificate of		u Mentai n	_	g. No.	
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)				Date of Death Month		3. Time of Death
Medical Exami	iner	JUDY LYNN WOJCIK 4a. Facility Name (if not institution, give street and number)	141	h City Town or	Location of Death	January 13	4c. County of E	0920 hrs
		1244 New Bridge Road	41	Pocomoke			Worcester	
Funeral			s. last birthday)	If Under 1 Year		-	(MM/DD/YYYY)	B. Birthplace (State or Foreign Country)
Director		$214-88-0509$ $_{1 \text{ M}} \text{ XX}_{\text{F}}$ 41	Yrs.	Months Days	s Hours Min.	02/21	/1966	Maryland
any		Usual Residence of Decedent 10a. State 10b. County 10c. Cit	ity, Town or Location	on	-			10d. Inside City Limits
* .	٦c	MD Wicomico Wil	llards					1 Yes 2 No
Maryland r 28a-f sho d at once	Director	10e. Street and Number		10f. Zip Code			g. Citizen of What	Country?
ith the 23a ou n. tiffu		7352 Richardson Street 11. Marital Status 12. Was Decedent Everin	11.S 113 W/25	21874	spanic Origin? (Sp		USA	American Indian, Black,
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after d	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 7	Yes 2 X No				White
hours "natul	70	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)			tion (Give kind of v . DO NOT use reti		16b. Kind of Busin	ness/Industry
036 ithin 7. ne. r than fedical	Complete	12 2	Certif	fied Nu	rsing .	Asst.	Health	care
15-0 filed with Hygie dother	e Col	17. Father's Name (First, Middle, Last) William Timmons			18.Mother's Name		laiden Surname)	
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Stree	Linda I		ber, City or Town,	State, Zip Code)
MD rd 2 sho alth and m 27 is		Clifton Lee Sparrow, Jr.				, West	over, M	
		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Salah	b. Place of Disposit crematory or other	tion (Name of cer er place)	metery,	Date	20c. Location - C	ity or Town, State
Baltimore, permit. Pages I al Department of He Important: If ite		4 Donation 5 Other Specify:						
Bal permi Depar Impo injury		21. Signature of Funeral Service Licensee	1 O 5	ame and Address	or Facility Ho.	lloway	Funera	l Home, P.A. tv. MD 21851
Physician		23a. Part I. Enter the disease, or complications that caused the dea failure. List only one cause on each line.	th. Do not enter the	e mode of dying,	such as cardiac o	r respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
Medical kaminer		Immediate Cause (Final disease a. Blunt Force Injuries						Death
		or condition resulting in death) Due to (or as a consequence	e of):					
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	e of):					
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executed an and al - transi	ical E	d.						
50, te be e nysician e burial	/ledio	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of processing the second of the seco	regnancy				23d. Date of de	elivery
687(ertifica ding ple e as the	ian/N	23b. Was decedent pregnant in the past 12 months?	2 Feta	al death 3	Ectopic pregna	ancy	Month	Day Year
30x death c ne atten I for us	Physician/Med	1 Yes 2 No 9 V Unknown g Unknown	death 5 Oth	ner (Specify)				
Division of Vital Records, P.O. Box 68760, within 24 bours after death certificate be executed within 24 bours after death. To the Tuneral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	by Ph	Part II. Other significant conditions contributing to death but no	it resulting in the ur	nderlying cause	given in Part I.			ute to the cause of death?
cords, P.O. aw requires that the ras been signed by 2 should be detach	ted b			 		1 Yes		Probably 4 Unknown ere autopsy findings available
COFC law rehas be	Completed		-			autop	sy pri	or to completion of cause of ath?
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of Vital Reco ing Physician: The law After this certificate has uneral director, page 2 si	To Be	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient		Othor	ng Home 5	Residence 6	Other: Scene
Division of Vital Records, tal or Attending Physician: The law requint at a star deal. In Director: After this certificate has been sided in by the funeral director, page 2 should be		27. Manner of Death 1 Natural 5 Pending FOUND: Day, Year)	28b. Time of In FOUND:		iry at Work?	28d. Describe I Subject was	now injury occurred beaten	
VISIOR or Attend after death Director: in by the	icatio	2 Accident Investigation Jan 13, 2008	0841 hrs		Yes 2 No	28f Location (5	Street and Number	or Rural Route Number, City
Divi	Certification:	3 Suicide 6 Could not be determined (Specify) Found in		., (2010)	and ing, oto		tate) dge Road, Poko	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:		29a. Certifier 1 Certifying Physician: To the best of my knowledge Certifying Physician: To the best of my knowledge Certifying Physician:	edge, death occurr	red at the time, d	ate and place, and	due to the caus	e(s) and manner a	s stated.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and manner stated. 29b. Signature and title of certifier	and/or investigate	29c. Licens		at the time, date		e to the cause(s)
	-	and the sand		O.C.			January 14,	
		30. Name and address of person who completed cause of death (Ite	em 23a)					
BA 5		Pamela E. Southall, MD Assistant Medical Ex		1 Penn Stree	t, Baltimore, I	MD 21201		
S Regis	tate trar	31. Date filed (Month, Day, Year) JAN 2 5 2008 32. Registrar's Sign	ature	raile				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #29c, perEVR, g876, 2/7/08 TCertificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** PATRICIA MAE WRIGHT $12:11P^{M}$ JANUARY 30 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2110 MARDELLA DRIVE WALDORF CHARLES 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 45 Director 213-84-7719 JULY 15,1962 VIRGINIA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show 10b. County ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No MARYLAND CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2110 MARBELLA DRIVE 20601 U.S.A. death Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc filed within 72 hours after 1 Yes 2 No If Yes, Give Y Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE 3 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any Injury or other traumatic event." (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DISPATCH SUPERVISOR 12 COMCAST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LAVURN BROWN OLA MAE HOWARD ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHEILA BROWN-SISTER 5027 FALLEN TIMBER WAY INDIAN HEAD, MD. 20640 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) METROPOLITAN CREMATORY 2-5-08 ALEX., VA. 2. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 21. Signature of Faneral Service Licenses MQ0479 5635 WASHINGTON AVE. LA PLATA, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 3hu DUN /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a ponsequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy fo in the past 12 months? 1 ☐ Yes 2 No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2▼ No 24a. Was an page 2 autopsy perform 20 No 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 [Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of After t 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation Injury death. 12:11PM 1 ☐ Yes 2 ☑ No Hospital or Attend 24 hours after death. Funeral Director: A face 2 Accident 30/2008 filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) ZIIC Man Della D Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide MO 24 hours a Walder. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hos within 24 ho To the Fun completely Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1/30/2008 D50883 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) La pluta MD 20646

Registrar DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Year)

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. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Henry John Wulforst /Medical 23, 2008 10:55a January 4a. Facilify Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney Montgomery If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 1√2 M 2□ F Hours Director 148-07-0246 May 30, 1918 New Jersey Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 2 14400 Homecrest Road, Apt. 53 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No if Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: ģ ^{Specit}₩hite 3 Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Plumber Plumbing Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Henry Wulforst Mary Margaret O'Hare ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau Everett W. Merritt/ Friend 4608 Hornbeam Drive, Rockville, MD 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** remana /Medical Due to (or as a consequence of) Examiner res Sequentially list conditions, if any leading to in model cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Sep 5/S

Due to (or as a consequence of): The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760. physician Physician/Medical the attending properties of if yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 □ Yes 2/ Nio 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performe certificate 2 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No dire 1 Tyes Certification: To 1 mpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 □ Yes 2 □ No 2 Accident after death

Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 124 hours a filled Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

31. Date filed (Month, Day,

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30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

2008

Year)

JAN 24

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year LEWIS FRANKLIN 8000 WELCH 2008 29 /Medical 01 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Garrett Coun Menorial HOSP an (tarre 9 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 'ear If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 8. Date of Birth (Month, Day, Year) 1**X** M 2□ F Months Days Hours Min 214-34-1386 Director Dec 16 1936 Usual Residence of Decedent with the Maryland 10a. State 10b. County ir than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD Garrett Kitzmiller 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P.O. Box 301 death 21538 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 □ No 1957 t Year or Dates: 1961 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No to Specify: Completed by Specify: 3 ☐ Widowed 4 ☑ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Heavy Equipment Operator Coal Mining 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fil thent of Heelth and Mental H tant: if item 27 is marked ott jury or other traumatic even Be 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles R. Welch Hazel M. Huffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 301, Kitzmiller, MD 21538 Lewis F. Welch, Jr., Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Kalbaugh Cemetery 2/1/2008 Elk Garden, WV 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
David A. Burdock Funeral Home, P.A. Katheren Durchy 710 Church St., Kitzmiller, MD 21538 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Arteriosclere /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the burial-transit pue Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. physicien Physiclan/Medical for use as JE FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 99 icete hes been sig , page 2 should b Be Completed 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy this certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No 20 No funeral director. 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 Inpatient Cthen 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3□ DOA 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 ☐ Natural 2 ☐ Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: All completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 1/ Certifying Physician: To the best of my knowledge, death accurate at the time, date and place, and due to the cause(s) and manner as stated.
2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 17 Le15 of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 2008 Registrar

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Baltimore,	permit. Pages 1 a Department of Hes Important: If item any injury or othe once.		 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice 		21100 1	2. Name and Addres	ss of Facil	ity Newman Fr	uneral	Homes	, P.A.
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	that the death certifica ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn		75-4			23d	Date of del	
Вох	d for u	iciai	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c		☐Ectopic pregnancy ☐ Other (specify) _	у			Month	Day Year
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0349 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 01-29-2008 **Physician** ROBERT N. WARREN JR. 09:30 A M /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOMEWOOD RETIREMENT CENTER WILLIAMSPORT WASHINGTON Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number Age (In vrs. last birthday) **Funeral** Days Months 88 03-22-1919 217-16-9354 CAMBRIDGE, MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director WASHINGTON WILLIAMSPORT 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code US 16505 VIRGINIA AVE. 21795 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: ģ 3 XWidowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) SERVICE PHONE COMPANY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROBERT WARREN BLANCHE PHILLIPS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) STEVEN R. WARREN 3510 FARRAGUT AVE., KENSINGTON, MD 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State WVU MEMORIAL VAULT 4∑Donation 5 ☐ Other (Specify) 01-30-2008 MORGANTOWN WV 26506 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WVU HUMAN GIFT REGISTRY MORGANTOWN WV 26506 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bladder Carcinoma 2 years Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical ģ Completed Be Certification: To

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, ours after death. Ieral Director: After this certificate has been signed lifiled in by the funeral director, page 2 should be det the Hospital within 24 hours a

To the Funeral I

IF FEMALE: 23b. Was decedent pr in the past 12 mc 1 ☐ Yes 2 ☐ N 9 ☐ Unknown	onths?	23c. If yes, outcome pf pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dead	23d. Date of Month	delivery Day	Year						
		contributing to death but not result		cause given in	Part I.	23e. Did tobacco	,		se of death? 4 ∐Unknown		
Atherosc	lerotic	Heart Dise	eas e			24a. Was an autopsy performed? 1 Yes 2	prior death	to completion	dings available on of cause of		
25. Was case referred	to medical		26. Place of Death (Check only one)								
examiner? 1 ☐ Yes 2 ☑ No		Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3 ☐ I	ome 5 Residence	6 □Other (S	Specify)					
2 Accident	5 □ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ∐ Yes	2 □ No	28d. Describe how injury occurred					
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At hon building, etc. (Specify)	ne, farm, street, facto	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
DOs Cartifier 1	Continue Dh	weiging: To the heat of my know	ladge, death occurr	ad at the time d	ate and place	and due to the cause	(e) and manna	r ac etated			

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D47451

29d. Date signed (Month, Day, Year)

State Registrar (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Home, 16505 Virginia Avenue Cynthia Kuttner-Sands, mo Homewood Nursing Home, Williamsport, Maryland 21795 32 Registrar's Signature

Kuttrer-Sands, no

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY 2008 11:00 PM MONA MARY ARZT 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ROCKVILLE NURSING HOME ROCKVILLE MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 02/12/1923 Birthplace (State or Foreign Country) 1 □ M 2 🕅 F Months Days Hours Min. 225-20-0541 84 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2 X No MONTGOMERY ROCKVILLE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 11401 BROAD GREEN DRIVE 20854 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: WHITE 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) OWNER APPLIANCE STORE 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ABRAHAM MINTZ LILLIAN METSKY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, RHODA SHULMAN / DAUGHTER 11401 BROAD GREEN DRIVE, POTOMAC, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 □Removal from State BALTIMORE HEBREW 02/07/2008 REISTERSTOWN, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. <u>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Healt oncestive Due to (or as a consequence of): Hypertension Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last iones of: Dementic Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Year Dav 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Director

r than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at

with the Maryland show

death 1

filed within 72 hours after

and Mental Hygiene.

ages 1 and 2 should be fill out of Health and Mental H to If item 27 is marked otty y or other traumatic even

permit. Pages 1 Department of H Important: If ite any injury or ot

Baltimore, Maryland 21215-0036

the death certificate be executed burial-trar and physician the as attending p the ģ signed I has certificate To the Hospital or Attending Firyswice... within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

P.O. Box 68760,

Division or Vital Records,

Examine Physician/Medical þ Completed Be Certification: To 27. Manner of Death 1 Matural

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

2 Accident

3 ☐ Suicide

29a, Certifier

Medical

State Registrar 4 ☐ Homicide

autopsy perform 1∐ Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 TYes 3□ DOA

1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of

Injury 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an

28d. Describe how Injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

determined

29c. License number D0064624 29d. Date signed (Month, Day, Year) 06,2008

20878

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No

2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANDEEP SHARMA

31. Date filed (Month, Da

Walk Dr. 743 Summer 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Larry Lincoln Bucklew February 2008 /Medical 8:10am 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Olney
If Under 1 Year | If Under 24 Hrs. | Hours | Min. Montgomery General Hospital Montgomerv Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 **X**M 2□ F 220-40-5237 Director 65 Feb 21, 1942 WV Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show the notified at Show MD Montgomery Brokkeville Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a odical Examiner must b 2600 Triadelphia Lake Road 20833 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black. White, etc. within 72 hours after 1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1962-64 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 2 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Je filed wh.

¬I Hygiene.

¥r than "r Elementary/Secondary (0-12) College (1-4or 5+) CEO Claims Processing 2 should be filed w and Mental Hygie Is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Monroe Bucklew, Sr. Mildred Ruth Strauser Mr. Jack Riggs Davis, Jr. f Health if 2600 Triadelphia Lake Rd., Brookeville, MD 20833 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages 1
Department of H
Important: if ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 2/8/2008 Sykesville, MD 21. Signature of Funeral Service Licensee HATCHT ACOMERAL HOME & CHAPEL, PA (Box 195) LT MO0764 House Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Massive Intracerebral Hemorrhage. 16 hours. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, i.e. ling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician Physician/Medical the as attending properties as 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 NG 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate perform 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation death. after death 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated.

within 24 hours a

To the Funeral [

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

omes

Thomas E. Dooley, M.D. 71904 Georgia AVenue, Olney, Maryland 20830 32. Registrar's Signature

30. Name and address of person who completed cause of leath (Item 23a) (Type, Print)

29c. License number

D16458

29d. Date signed (Month, Day, Year)

February 6, 2008

For State Registrar

Director

Funeral

Be Completed by

ို

Examiner

Physician

/Medical

Examiner

Funeral Director

Plea	ise Type or Pr					_	
For State	State of N	aryland / Der Co	ertificate of			. No. 2 A A S	0.001.0
Registrar 1. Decedent's Name (First, Middle)	le, Last)		<i>57 67710</i> 67 67		2. Date of Death	2000	3. Time of Death
Doris Ma	37	Buckmas	ter		February	7,2008 Year	9: 15 A ^M
4a. Facility Name (If not institution				or Location of Death		4c. County of Deat	h
340 South High			Balti	more			
5. Social Security Number	6. Sex 7. A	Age (In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	(ear) 9. Birt	hplace (State or Foreign
214-18-1518	1 □ M 2X F	85 Yrs.	Wioritis Days	Tiours IIIII	January 21	,1923 Mar	yland
Usual Residence of Decedent		10c. City, Town or	Logation				10d. Inside City Limits
10a. State 10b. County							1 X Yes 2 □ No
Maryland N/	<u> </u>	Baltin			100	. Citizen of What Co	
10e. Street and Number			10f. Zip Code	1004	109		untry?
340 South Highl				1224		USA 14. Race - Ame	rican Indian
11. Marital Status	12. Was Deceder Armed Forces	5?	 Was Decedent of I If Yes, specify Cut 	Hispanic Origin? (Sp an, Mexican, Puert	o Rican, etc.)	Black, White	
1 ☐ Never Married 2 ☐ Mar	If Yes, Give		1 ☐ Yes 2 X No	Specify:		Specify: Wh	nite
	nt's Education est grade completed)	(Gi	cedent's Usual Occu ve kind of work done	dunna most of work		6b. Kind of Business/	Industry
Elementary/Secondary (0-12)	College (1-4o	r 5+)	e. DO NOT use retire	ea)		O 77	
7 years		Ho	usewife	10 Mathada Nam	ne (First, Middle, Ma	Own Home	
17. Father's Name (First, Middle					anna Roed	·	
Charles M. Hume		1,2,3					7:- 0- 4-1
19a. Informant's Name/Relations Joan Neville	Daughter					City or Town, State, 2 timore, MI	
20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 4 □ Donation 5 □ Other (:		cemetery, c	sposition (Name of crematory or other plan n Cemetery	1	ruary	oc. Location - City or undalk, Mai	
21. Signature of Funeral Service	Licensee		22. Name and Addr Connelly 1 7110 Solle	ess of Facility Funeral He ers Point	ome Of Du Road, Du	ndalk,P.A. ndalk,MD.	21222
23a. Part. Enter the disease, of shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a	ed the death. Do not of line. A SCVI as a consequence of): A SCVI as a consequence of):	enter the mode of dy	ing, such as cardiac	c or respiratory arres	st,	Approximate Interval Between Onset and Death
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	OPD					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death at time of death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	су		23d. Date of de Month	livery Day Year
Part II. Other significant condit	ions contributing to death	but not resulting in the	e underlying cause g	ven in Part I.	23e. Did toba		o the cause of death? robably 4 ☐Unknowi
					24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
25. Was case referred to medic	al				ath (Check only one,)	
examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpa	itient 2 ER/Outpat	tient 3 DOA Ot	her: 4 Nursing H	lome 5 Resider	ice 6 Other (Spe	ecify)
27. Manner of Death 1 Natural 5 ☐ Pendi	28a. Date of Ing (Month, I	njury 28b. Time Day Year) Injur	y Wo	ury at ork?]Yes 2 ☐ No	28d. Describe hov	v injury occurred	
3 Suicide 6 □ Could	not be 28e. Place of	injury - At home, farm, etc. (Specify)			28f. Location (Stre	eet and Number or R State)	ural Route Number,

Physician /Medical Examiner within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

Physician/Medical IF FEMALE: 23b. Was dece in the past 9 Unkno Part II. Other si Be Completed by 25. Was case r examiner? 1 Tyes Medical Certification: To 27. Manner of D 1 Natural 2 Accider 3 Suicide 4 Homici Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (*Month*, *Day*, *Year*) 29c. License number 29b. Signature and title of certifier 0024303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) FEB 0 8 21

32. Registrar's Signature

21226

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $U \cup S$ 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ERNARA 35 RECHT 29 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death County of Death Examiner BALTIMONE BALTIMORE MULLING home 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 unle 6. Sex **Funeral** -94-8110 Months Days Hours 1 9-M 2 F unk Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State X□Yes 2□No Director Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21215 2525 W. Belvedere Avenue Completed by Funeral unk 12. Was Decedent Ever in U.S. Armed Forces? U. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, unk Black, White, etc. 1 □ Never Married 2 □ Married Specify: white 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry unk College (1-4or 5+) Elementary/Secondary (0-12) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk unk Be ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2525 W. Belvedere Avenue Baltimore, MD 2121
of Disposition (Name of Date 20c. Location City or Town, State Blue Point Nursing Home 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department in important: if eny injury or once. 4 □Donation 5 🖾 Other (Specify) in state 21. Signature of Funeral Project Licensee Wade, Director State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death RESPIRATOR Immediate Cause (Final **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24a. Was an autopsy performed?
1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only or Other: 1 Yes 2 No Medical Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Detth 28d. Describe how injury occurred 28b. Time of 1 Natural 2 Accident Injury 5 ☐ Pending 1 Tyes 2 No investigation 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician. To the best of my knowledge, death conimed at the time, date and place, and due to the causa(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

or Attending Physician: The law requires that the death certificate be executed Records, P.O. Box 68760, Division of Vital

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene. ant: if Item 27 ie marked other then "natures", or Items 23e or 28e-f ehow

Baltimore, Maryland 21215-0036

ir then "nature!, or items 23a or 28a-f ehor tre Medical Examiner must be notified at

traumatic event,

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ed by the e

sete has been signed page 2 should be det

certificete

within 24 hours effer death.

To the Funarel Director: After this certific completely filled in by the funeral director,

To the

(Check only one)

30. Name and address

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FEB

DHMH 17 Rev 1/2001

State

Registrar

who completed cause of death (Item 23a) (Type, Hint)

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 1530 M BLOCK JANUARY 29 2008 SAMUEL 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE CITY HOSPITAL THE JOHNS HOPKINS If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, Days unk 1 M 2 □ F Oct 14, 093-50-4126 53 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 XYes 2 No Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21203 954 Forrest Street 14. Race - American Indian, 12. Was Decedent Ever in U.S.UN 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? unk 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married black 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced 16b. Kind of Business/Industry un 16a. Decedent's Usual Occupation unk 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 600 N. Wolfe Street Baltimore, MD 21287 Johns Hopkins Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Nother (Specify) in state State and Addronly a Board 655 W. Baltimore Street 21. Signature of ineral rivice Licensee Wade Director Baltimore, MD 21201

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate (Final disease or condition resulting in death) DAY HYPERKALEMIA Due to (or as a consequence of) DAYS RENAL FAILURE Due to (or as a consequence of) DAYS SEP515 Due to (or as a consequence of) DAYS PNEUMONIA KLEBSIELLA 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown IMMUNO DEFICIENCY Were autopsy findings available prior to completion of cause of 24a. Was an PNEUMOCYSTIS JAROVECLI autopsy death? 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

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page 2 should

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After th funeral

Director:

in 24 hours the Funeral Directory filled in by

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physician

be executed

law requires that the death certificate

Box 68760.

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Records,

Division or Vital

the Hospital or Attending

hours after death.

Physician

/Medical

Examiner

Funeral

Director

ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 Is marked other than Irry or other traumatic event, the Ms

permit. Page Department o Important: If i any injury or

Baltimore,

Director

Funeral

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Completed

Be ပ

Examiner

Physician/Medical

Completed

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Certification:

Medical

filed within 72 hours after death with the Maryland

Sequentially list conditions, if an, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

2× No 1 ☐ Yes

27. Manner of Death 5 Pending investigation

6 ☐ Could not be

1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only

Natural

2 ☐ Accident

3 Suicide

4 Homicide

Scritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

Medical Doctor

RES-000

29d. Date signed (Month, Day, Year) January

Baltimore, MD 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Trindade, MD Johns Hopkins Hospital 600 North Wolfe Street 32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 0 8 2008

State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day Dorothea Н. Burrer February 2008 11:00 1, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 9205 Rosehill Drive Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 070-12-2266 90 Director January 16, 1918 Washington, D.C. Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland | Montgomery Bethesda the ? 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? with t 9205 Rosehill Drive 20817 Funeral United States death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2本 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White **a** Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within ealth and Mental Hygiene. n 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 0wner Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Yonezi Inazawa traumatic Henrietta Prehn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau Barbara B. Harris/Daughter 4010 Holly Knoll Drive, Glen Arm, Maryland 21057 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery 20a. Method of Disposition Date 20c. Location - City or Town, State February 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 2008 Crematorium, Inc. 21. Signature of Juneral Service Vcensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy M00198 7557 Wisconsin Ave., Bethesda, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Lung Cancer year /Medical Due to (or as a consequence of): Examiner Tobacco Smoking 30 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed and burial-tran Due to (or as a consequence of): Box 68760. physician Physician/Medical the attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No 4□Pregnant at time of death Month Day Year 5 Other (specify) P.0. the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 A Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy perform certificate 1∐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 🛭 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident d in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide n 24 hours. the Funeral Dire 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only To th. within 2-29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D33443 February 4, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Veronica DiFresco, M.D. 1201 Seven Locks Road #111, Rockville, Maryland 20854 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #8, perFH,0876, 2/8/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY **Physician** 6:29P 2008 BARBARA BERNHARD /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CARROLL 708 DEER PARK ROAD WESTMINSTER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months 1 □ M 2 X F 72 11/15/35 **193**5 224-40-0340 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 'natural', or Items 23a or 28a-f show dical Examiner must be notifled at 1 ☐ Yes 2 No Director WESTMINSTER MD CARROLL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 708 DEER PARK ROAD 21157 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give 11. Marital Status 1 Never Married 2 Married WHITE 1 ☐ Yes 2 🕅 No Specify. If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) within 72 College (1-4or 5+) Elementary/Secondary (0-12) NURSING REGISTERED NURSE s 1 and 2 should be filed w f Health and Mental Hygier them 27 is marked other th other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY EVELYN UNKNOWN **HOWARD** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2. Department of Health a Important: If Item 27 is 708 DEER PARK ROAD, WESTMINSTER, MD ROBERT BERNHARD / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State HAR SINAI CONG. 02/07/2008 OWINGS MILLS, MD injury o 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Inter the disease, over implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or hand failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) -/Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Due to (or as a consequence of) physician Physician/Medical the attending IF FEMALE use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year for 1 Month Day in the past 12 months? 5 Other (specify) 4 Pregnant at time of death ☐Yes 2☐No the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MELLITY 5 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes No 24a. Was an was and autopsy performed?
Ves 2 1 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tyes 2 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After (Month, Day Year) 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

certificate be executed Division or Vital Records, P.O. Box 68760.

hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Hospital or Attendl within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State Registrar

Medical

29a, Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number D25052

🔭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 CROSS RONDS

541TE 102 DRIVE, DWINIGS MILLS

31. Date filed (Month, Day, FEB

32 Registrar's Signature

08-0 Cat

08-01018 Cathy Carr			or Print in Bl e of Maryland								ible	200	8 0349
		- For State Registrar		Cer	tifice	te of Deat	h		I o p		g. No.	200	
Physician Medical Examin	1,1	1. Decedent's Name (First, Middle,L	est) CARR-	_ Ka	thy	Carr				te of Death nth oruary 4		Year 8	3. Time of Death 2140 hrs
	-	4a. Facility Name (if not institution, g Harbor Hospital	ive street and number)			4b. City, 1 Baltin		Location of D		<u></u>		County of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birth Foreign Court											
any	F	Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town	or Location							10d. Inside City Limits
*	_	MD				MORE							1 X Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number				10f. Zip				10g. Citizen of What Cour			try?
ith the 23a or notifie		3710 BELLE AVEN	UE 12. Was Decedent	Ever in II	9	13. Was Decede	215	enanic Origin	2 (Specify)		JSA	14. Race - Americ	ean Indian Black
leath w	Funeral	1 X Never Married 2 Marrie	Armed Forces		J.			n, Mexican, Po				White, etc.	
safter c	Ð.	3 Widowed 4 Divorc	ed If Yes, Give Year or Dates:					specify:		_		Specify:BLAC	
2 hours "natu"		15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade cor College (1-4 or			Decedent's Usual Juring most of wo				one	16b. K	ind of Business/I	naustry
036 Athin 7 ene. er than Medica	Completed		4		JO	OURNALIS'	Γ					EWSPAPER	
21; be fill intal F rrked	Be	17. Father's Name (First, Middle, La LEWIS CARR						18.Mother's N	FEAS	TER			
MD 21. od 2 should the offith and Mer in 27 is mar aumatic even	<u>٩</u>												
Ore, ges 1 and to freal tree in the tree tree in the t		20a. Method of Disposition 1 X Burial 2 Cremation	Removal from St	ate	remate	f Disposition (Nar ory or other place LAWN CEM)		Date			Location - City or	
Baltimore, permit. Pages 1 ar Departament of Hee Important: If ite	ŀ	4 Donation 5 Other Spec 21. Signature of Funeral Service Liq	ify: ensee	0									NS F.H., INC
Permy Permy Depty Imp		Vames (1. Who	ten		1	701	LAUREN	S ST.	, BAI	LTO.	, MD 21:	
Physician /Medical		23a Part I. Enter the disease, or confailure. List only one cause on	each line.				of dying	, such as card	diac or respi	ratory arre	est, sho	ck, or heart	Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Gastrointestina Due to (or as a cons										Death
	_	Sequentially list conditions,	b. Bleeding Esoph			S							
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a cons	equence o	r):								
executed an and al - transit	Exa	events resulting in death) Last	Due to (or as a cons d.										
be exectician are urrial - t	dical	was amended 1 per me g876 2-8-08 v							8 vt				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco 1 Live birth 4 Pregnant a		2			Ectopic p	regnancy		230	d. Date of delivery Month [oay Year
. Bo the deat y the at	ᇍ	1 Yes 2 No 9 Unkno	9 OTIKITOWIT	th but not re	e ultin	in the underlying	n cause	niven in Part	ı I:	23e. Did to	bacco	use contribute to	the cause of death?
s, P.O. Be irres that the de signed by the dedetached f	≦		S contributing to deal			y in the underlying	9 00000	9.70.7.11.7 u.t.		1 Yes	2 🗸	No 3 Prob	pably 4 Unknown
cords, law requir has been s	mpleted	-							_ ²	24a. Was autop autop perfor			topsy findings available completion of cause of
Vital Rec sysician: The la this certificate h director, page	ပို	25. Was case referred to medical					26 Plac	e of Death (C	heck only o	✓ Yes	2 N	0 1 Y Ye	es 2 No
Vital hysician this cert	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpati	ent 2 🗸	ER/O		OOA	Othor	Nursing Hon		Reside	ence 6 Other	:
on of vending Phath.		27. Manner of Death 1 Natural 5 Pending		ury Yeer)	28b.	Time of Injury		ury at Work? Yes 2 N		Describe I	how inju	ury occurred	
Divisior pital or Attend ours after death eral Director:	Certification:	2 Accident Investig 3 Suicide 6 Could n 4 Homicide	ot be 28e. Place of I	njury - At h	ome, fa	arm, street, factory	y, office	building, etc.		ocation (S		ind Number or Ru	ral Route Number, City
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the 1	Medical C	29a. Certifier 1 Certifying Phys	ician: To the best of mer:On the basis of exa										
To the within Fo the compl	Mec	29b Signature and title of certifier	and manner stated					se number				Date signed (Mo	
(2)		J. Name and address of person wh	Lews	death (Item	23a)		0.0	.M.E.			Feb	ruary 5, 2008	3
		Laron Locke MD. Ass	istant Medical Ex			Penn Street	t, Balti	more, MD	21201				
Sta Regist	ate rar	31. Date filed (Month, Day, Year)	2008 32. Registra	ar's Signati	ar a	A334	9						

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year /Medical bruary 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5304 Merceron Avenue Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 M 2 □ F Days Hours Director <u>216.34.9813</u> 05.26.1940 MD Usual Residence of Decedent with the Maryland show 10a. State 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits Director 1: Nes 2 □ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with and Mental Hygiene.

Is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be r U.S.A. Funeral 21207 5304 Merceron Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ☐ Yes 2 Yes, Give 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ò Specify Specify: Black 3 ☐ Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grounds Keeper Baltimore City traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Jesse Carter ဂ Molinda Craft 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Jessica Carter/Daughter</u> 5923 Western Park Dr., Baltimore, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 1 ☐ Burial 2 🚾 remation 3 ☐ Removal from State Chesapeake Crem. 4 ☐ Donation 5 ☐ Other (Specify) 02.07.08 Beltsville, MD 22. Name and Address of Facility CAFA/ Stephen D. Lohrmann, 21. Signature of Funeral Service Licensee EPPNOM P.A. 8717 Green Pastures Dr. Balto., MD 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bladde **Physician** years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to for as a nonsectionice of if in cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed an burial-trar Due to (or as a consequence of): attending physician for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) ed by the detached 9 ☐ Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No page 2 s 24a. Was an has autopsy certificate 2 No 1□ Yes 2 X No Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred (Month, Day Year) Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H53088 February 6,2008

State Registrar

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31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

BALTIMOREMARYIAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Year)

08